Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 5:15 p <sup>M</sup> 2007 December Margaret H. Doyle /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville Copper Ridge 8. Date of Birth (Month, Day, Year)
Oct. 14, 1918 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** New York Days Hours 1 ☐ M 2 🔀 F 022-14-4720 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 XNo Director Mď. Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21093 USA 134 Hollow Brook Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Benefits Co. Proof Reader 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcella Fosbinder Ralph C. Young 70 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Hollow Brook Rd. Timonium, Md. 21093 Marjorie H. Doyle/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-6-07 4 □ Donation 5 □ Other (Specify) Hilltop Service Co. Towson, Md. 21. Signature of Fureral Service 22. Name and Address of Facility Ruck Towson Funeral Home 1050 York Rd. Towson, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0 been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို funeral 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Matural Natural Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stone 31. Date filed (Month, Day, Year strar's Signature State

DHMH 17 Rev 1/2001

Registrar

06

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 4, 2007 6:38 а м Davisson Mary Emily 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay, Year) May 1, 1981 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🔽 F CăTifornia 26 230-23-6477 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 1 □ Yes 2 □ No Baltimore Rosedale MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 U.S.A. 2363 Hamiltowne Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 2 XNo 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) School Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orlando Davisson Mary Helen Thomsen Edwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2363 Hamiltowne Cir., Rosedale, MD 21237 Edwin O. Davisson-father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv. Corp 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/6/07 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ERE BRAL Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner?

Yes 2□ No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Examiner and -transit certificate be executed attending physician a for use as the burial-Box 68760, signed by the a Division or Vital Records, P.O. has To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital o within 24 hours aff To the Funeral D

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show digal Examiner must be notified at

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event the Manager Industrial or other I

**Physician** /Medical Director

Funeral

Š

Completed

Be

Examiner

Physician/Medical

Completed by

Be

P

Certification:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

KOLLINGS

29a. Certifier

RAMANA hospital Mil who completed cause of death (Item 23a) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12/5/2007

IMORB

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** M Rosario Deduca 29 2007 1:07 MUU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bas to won Parksille Cremesis If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) unk 6 Sex 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours Min 1 M 2 □ F Yrs. 90 Director Mar 20, 1917 212-05-2772 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 9630 Mason Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? un 14. Race - American Indian 11. Marital Status Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X ☐ No Specify. Be Completed by 3 Widowed 4 Divorced unic 16b. Kind of Business/Industry unit 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genesis Perring Parkway 1800 Wentworth Road Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or 4□Donation 5\\\Other(Specify) in state wade/ 21. Signatur, of Funeral Service Lic State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Macumonia derys /Medical Due to (or as a consequence of): **Examiner** month 3 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 □ Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, been signe should be Completed by malantahu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mahyser 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed: page death? 1 ☐ Yes certificate 2□ No 1☐ Yes 2 1 No comen 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) P 1 Tes 2 1√0 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending After 5 Pending investigation 1 Natural Vision of the Function of the 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) XLUL 200 D31291 11/30/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sute 4202 Towar Moesz 31. Date filed (Month, Day, Year) 32. Physistrar's Signature State 06 200 DEC SERVE Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #6 Per FH G874 12/18/09er#ficate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death Day **Physician** Joseph Martin Dominiak December 4,2007 12:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Nursing Center Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months MXX 88<sup>Yrs.</sup> Director 218-05-6196 5.1919 May Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show iral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6810 Boston Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1944 − 1 1974s 2 □ No 1946 − If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify. Specify: White 3 Widowed 4 Divorced "natural" and 2 should be filed within 72 hour alth and Mental Hygiene.
127 is marked other than "natural er traumatic event, the Medical E. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Inspector <u>General Motors</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Dominiak Sophie Knotek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trau Frances Dominiak - Wife 6810 Boston Ave. Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Stanislaus Cem. Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached Division or Vital Records, P.O. the 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1□ Yes 21 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D27188 December 5, 2007 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savinder Julka, M.D. Market Place Dundalk, MD 21222

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 6

2007

32. Registrar's Signature

		For State Registrar	State of M	aryland		artment of F <i>rtificate of</i>		d Mental Hy	giene Reg. No.	2007	20005
4 2		Decedent's Name (First, Middle, L.)	ast)					2. Date of D	eath		3. Time of Death
Physicia		Mary G.	Erlandson					DECEM	BEK Day	Ø3, Year	27 09:03FM
/Medic Examin		4a. Facility Name (If not institution, g Saint Josep	ive street and number)	l Cer	nter	4b. City, Town, o				County of Deat	
Funeral	-	5. Social Security Number 6.	Sex 7. Ag	je (In yrs. la	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days		in. (Month, D	ay, Year)	Co	hplace (State or Foreign untry)
Director		220-18-7629 Usual Residence of Decedent	8					Septem	ber 2	4, 1922	
Marylan -f show ied at	tor	Md. State 10b. County Baltimo	re	10c. City	,TownorLo nium	ocation					10d. Inside City Limits 1 ☐ Yes 2 💢 No
ith the or 28a	Director	10e. Street and Number		J		10f. Zip Code			10g. Citiz	en of What Co	untry?
ath w		641 Straffan Dr.				21093				U.S.A.	
tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? oan, Mexican, Pi	? (Specify Yes or Nuerto Rican, etc.)	0- 1	14. Race - Ame Black, White	
or 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Or Heath and Mental Hygiene filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1  Yes XX  If Yes, Give  Year or Dates:	No		1□Yes XX No	Specify:			Specify: Ш	iite
in 72 hc " <b>natu</b> Iedical	Completed	15. Decedent's (Specify only highest of	rade completed)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of ed)	working	16b. Kir	nd of Business/	Industry
ed with ygiene. ier thar t, the N	Com	Elementary/Secondary (0-12)	College (1-4or	5+)	Homer	maker	T			n Home	
d be fill entat H red oth	Be	17. Father's Name (First, Middle, La Robert Carn	•				18. Mother's	Name <i>(First, Middl</i> i <b>E</b> .	_	Surname) VNN	
should nd Me mark mati	ဍ	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street		r Rural Route Num		<del></del>	Zip Code)
5 = 2 E		Robert C. Erland				-		Luthervi			•
iges 1 ar nt of Hea if item:		20a. Method of Disposition	_		lace of Disp	osition (Name of matory or other pla	i	Date	<del>, '</del>	cation - City or	
Pages nent of I nt: If ite		1 <b>XX</b> Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			-	dge Cem.	· i	2-7-07	Balt	imore	
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Services in	<b>2</b> nsee		R <sub>I</sub>	2. Name and Addre	ess of Facility	al Home	Tnc		
and the same		23a Part1 Enter the disease or co	molications that cause	d the death	111	Jou York	Rd. Tou	ison.Md.	21 204		Approximate
area ser s		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final						oldo or rospitatory			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. KENH Due to (or as		ILURE	-					
Examiner			COAG								
<b>京</b> ·京·京	Je.	Sequentially list conditions,	b. Due to (or as	a conse	ience of						
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
ate be exe ohysician ar the burial-t	Щ.	resulting in death) Last	Due to (or as	a consequ	uence of):					- 1	
physici the bu	edical		d								
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🂢 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pregnand □ Other <i>(specify)</i> _	су		2	23d. Date of de Month	livery Day Year
at the de d by the a	Phys	9 Unknown	a a satisficação de alegado l		deline in the c	undoubline earles al	iven in Deut I	ago Did	tohennou	no contributo t	o the cause of death?
quires that en signed build be det	by	Part II. Other significant condition: CARDIAC DYSRHYTH	•	out not resu	alling in the i	gradenying cause gr	veirii Faiti.			□ No 3 □ P	١.
ne law requir has been si ge 2 should	Completed							24a. Wa	s an opsy formed?	24b. Were a prior to death?	utopsy findings available completion of cause of
sician: Th certificate rector, pag								1□ Yes	2 No	1 ☐ Yes	s 2 No
sicial certi irecto	Be o	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	Hospital:		ED/Outratio	ot ot	hor	Death (Check only			
ding Physician: The In. After this certificate he funeral director, page	1: To	27. Manner of Death	28a. Date of Inj	ury	28b. Time	IN SUIDOA	4 LI Nursii	ng Home 5 ☐ Re 28d. Describe			ecity)
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigal 3 ☐ Suicide 6 ☐ Could no determine	be 28e. Place of in	jury - At ho			Yes 2 No	28f. Location			ural Route Number,
ital or its after ral Dlir led in t	Certi	4 Nomicide	building, e	tc. ( <i>Specif</i> )	y)			City or T	own, State	)	
ie Hosp 24 hou ie Funei iletely fil	Medical		Physician: To the best caminer: On the basis and manners	of examina							
To th withir To th сотр	Me	29b. Signature and title of certifier	4-				nse number			te signed (Mon	
	1		1_			D4	46356		Dec	ember	r03,200

State

31. Date filed (Month, Pay, Year)
DEC 0 6 2007 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

7601 r's Signature

30. Name and orders of person who completed cause of death (Item 23a) (Type, Print)

DRIVE TOWSON, MARYLAND 21204

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month / 2 **Physician** serge Cator /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner LCOMANOR NUISING N/A - Rach Rose If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 6. Sey 1 M M 2 □ F If Under 1 Year 5. Social Security Number Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys Months Yrs. 212-36-8448 Director February 13,1939 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Yes 2□No N/A Baltimore Director 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 2095 RockRose Avenue 21211 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1√2 Yes 2 □ No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0020 Be Completed by 1 ☐ Yes 2√ No Specify: 3 ☐ Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Independent N/A 17. Fether's Neme (First, Middle, Last)
Joseph Elmer Eaton 18. Mother's Name (First, Middle, Maiden Surname) Rachel Buchman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Miller (Sister) 1132 Falls Hill Rd. Apt D4 Balto, MD 21211 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12/6/7 Catonsville, MD 22. Name end Address of Facility Burgee-Henss-Seitz 3631 Falls Road Ba 21. Signature of Funeral Service Licensee Funeral Home, Inc. alto, MD 21211 Balto, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner Vaseles Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mestive Jant Diseane Physician/Medical Due to (or as a consequence of) Cencer Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Laursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No within 24 hours aftar death.

To the Funeral Director; After this completely filled in by the funeral di 28c. Injury et Work? 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number D 31464 15107 Vor MD 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) St Inte 308, BALTIMORE SHUALIS A. HASHOMI 821 N, ENTAN 32 Registrer's Signeture 31. Date filed (Month, Day, Year) State Registrar DEC 0 6 2007

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jerome Edwards ,200 40 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A LTIMO HOSPITAL If Under 1 Year 8. Date of Birth (Month, Day, 1) Sept 30, Birthplace (State or Foreign
Country) Social Security Number Age (In yrs. last birthday) **Funeral** Year Days Min 1 XM 2 ☐ F 65 214-40-1260 Sept 1942 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No Directo N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 405 Lyndhurst Street 21229 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Garfield Edwards Elizabeth Kornegay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Forte, Niece 3900 Winlee Road Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/05/07 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** atheros electic cold iovoscul /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to for as a consequence of) burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical signed by the attending physid be detached for use as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending To the Hospital or Attendli within 24 hours after death.
To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

m

31. Date filed (Month, Day, Year) 32. DEC 0 6 2007

32. Redistrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

Gode

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per verb., 8874, 12/06/07dhb of Death

State of Maryland / Department of Health and Mental Hygiene per verb., 8874, 12/06/07dhb of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician November 24, 2007 John Frederick, Jr. 9:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospital Center Westminster Carroll County 6. Sex 1**X** M 2□ F 8. Date of Birth (Month, Day, You Jan. 24, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last hirthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-40-3739 1944 West Virginia 63 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified anonge. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 Harman Avenue 21230 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Types 2 No If Yes, Give 1967 Year or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: white 3 ☐ Widowed 4 🎖 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Frederick, Sr. Helen G. Golden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Frederick, III/Son PO BOX 491 Callao, VA 22435-0455 20a. Method of Disposition 20b. Place of Disposition (Name of MD Carpeter), crematory of other place)

MD Veteran Cemetery (11-28-2007 Crownsville 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Ambrose Funerally Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease of complications that set sed the shock, or heart failure. Est only one cause on each line. complications that we sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINU /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed j physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy rector page 2 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Yes 2 No P 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after Di e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ithin 24 to the Fu and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

(6+1)

State Registrar 30. Name and address of person who complete

HENDER

DEC 0 6 2007

HERBERT

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MANCHESTER RD. MANCHESTER

e of death (Item 23a) (Type, Print)

Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	-	•	ate of L		Remaining	eg. No.	7 00000
	Physici	an	1. Decedent's Name (First, Middle, L Rita 0	ast) • Freund					2. Date of Deat	<sup>h</sup> 2007	3. Time of Death ar 3:45 P M
	/Medic		4a. Facility Name (If not institution, g			4b. C	ity, Town, or	Location of Death	December	4c. County of D	
	LAGIIII	e i	Gilchrist				Towsor	า		Baltim	
	Funeral Director		216-12-9457	Sex 7. Ag 1 □ M 2X F	e (In yrs. last birth	rs. If Un Monti	der 1 Year ns Days	Hours Min.	8. Date of Birth (Month, Day, Jan 15,	1923	Birthplace (State or Foreign Maryland
	/land ow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	e Mar 3a-f sh tiffed	ctor	Md. Baltimo	re	Towso	n					1 □Yes 2□XNo
	ath with th 23a or 24 rust be no	ral Director	10e. Street and Number 8432 Charles			С	Zip Code 21204			0g. Citizen of What	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ODGE.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:			cedent of His pecify Cubar 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		umerican Indian, Vhite, etc. Phite
Maryland 21215-0036	ithin 72 ho ne. nan "natu	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5	(i+)	Give kind of life. DO NO		ition uring most of work	ing	16b. Kind of Busine	
121	filed w Hygier ther th	Cor	17. Father's Name (First, Middle, La.	st)	НО	memake		18. Mother's Name	e (First Middle M	Own Home	
lan	lid be lental rked o	To Be	Charles P. Born	•					Birner	narden barnamer	
lary	2 shou and N is mai		19a. Informant's Name/Relationship		1					, City or Town, Stat	
e, ≥	1 and Health em 27 ther tr		Mr. Gregory Freur 20a. Method of Disposition	d/ Son						Heights, 20c. Location - City	Mo. 63043
Baltimore,	it. Pages intment of intant: If It injury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)	20b. Place of I cemetery Hillto	p Serv	rice Co	12-6-	-07	Towson,	
Ba	Depa Impo any i		21. Signature of Fuer Viol Lic			1050	Tows	sg <sup>r</sup> ffühera Rd. Tows	1 Home,	Inc 21204	
	Physician /Medical Examiner		23a. Part1. Enter the disease or co- shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir _a	10.	CAR (		g, such as cardiac		est,	Approximate Interval Between Onset and Death MONTHS
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Duc to (or as	a consequence o	9:					
68760,	tificate be executed ig physician and as the burial-transit	Aedical Exar	that initiated events resulting in death) Last	C. Due to (or as	a consequence of	·):					
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3∐Ectopi 5 ☐ Other	cpregnancy (specify)			23d. Date of Month	delivery Day Year
	equires that en signed b	þ	Part II. Other significant conditions  BREAST CA	contributing to death b	ut not resulting in t	the underlyin	g cause give	n in Part I.	23e. Did tob	t .	e to the cause of death? ] Probably 4 □Unknown
al Records,		Completed								prior ned? deatl 2 No 1 □	
<u> </u>	Physician: r this certificaral director,	o Be	25. Was case referred to medical examiner?  1 Yes 25000	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3	Otho	26. Place of Deat		ence 6 🞾 ther (5	Specify) HASPLE
o u	ng Ph ifter thi	T:uc	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Day	ry 28b. Ti		28c. Injury Work			w injury occurred	specify) // Corr
Division or Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of init	ury - At home, farr c. (Specify)	M n, street, fac		′es 2□No	28f. Location (St. City or Town	reet and Number or n, State)	r Rural Route Number,
Ω	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier	Physician: To the best	of my knowledge.	death occurr	ed at the tim	e, date and place	and due to the ca	ause(s) and manne	r as stated
	the Ho in 24 h he Fur pletely	Medical	(Check only 2 Medical Exone)	aminer: On the basis of and manner sta	examination and	or investigat	ion, in my op	pinion, death occur	red at the time, d	ate and place, and	due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	0.20			29c. License			9d. Date signed (M	
	In		30. Name and address of person wh	o completed source of the	path (Itom 22a) (T	me Brint\	106	4375		DELEMB	ER 3.2007
_	10		DANIEUR DIBER	MAN, MO	0565 N	CHARLE	SST,	8417720	9 BPCT	TMARE, M.	ER 3,2007 0 21204
	Sta Registr		31. Date filed (Month, Day, Year)  DFC 0 6	32. Registra	ar's Signature	Gren	23				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Magth 6:30 AM **Physician** Feibel Gloria L. d Ô /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital enter Kosedale balhmor if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 X F 218-26-5921 Director June 24,1930 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 No Directo Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1713 Watervale Avenue 21222 <u>United States</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or item 1 ☐ Yes 2**X**No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. Specify: White Completed by 3 Novidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Years Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James L. Collins Willie Ruth Burton ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 297 Hazel Avenue Baltimore, Maryland Barbara A. Reisinger (Daughter) Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery: 12/5/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician archopulmonar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed HEAVTOLOG for use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 7 No has page 2 After this certificate 1□ Yes or Attending Physician: 26 Place of Death (Check only one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

Pibel

Franklin Square Drive.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

4000

32 Registrar's Signature

0000

Baltimore

200

28a-f ehow in then "natural", or iteme 23a or 28a-1 ehov The Medical Exemples must be notified at death filed within 72 hours after al Hygiene. or other traumatic event, . Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked ott permit. Page Department o importent: If any injury or once.

21215-0036

**Funeral** 

Director

Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 12/6/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Calter fmmediate Cause (Final **Physician** severe end Stage dilated disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner conquistive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Ar Tery 013 Ease coronary that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical cardiorespiratory for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent oregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by cate has been signe, page 2 should be COPD Anemia HYPERTENTION 1 Tes After this certification, I 25. Was case referred to medical Hospitaf: 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Naturat 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier Medical completely (Check only 29c. License number 29b. Signature and title of certifier RES 0000 M. 0 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) AL-ABBadi 4000 FRANKLIN Sauare DR. Baltimore

Reg. N6. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 0035 AM **Physician** 2007 December Arthur Funk Hugo 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Rosedale Baltimore Sayare HOSPITAL CENTER FRANKLIN If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 1∆ M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 72 Yrs. Maryland 216-32-5162 Nov. 21,1935 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Director Colgate 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7755 Eastdale Road 21224 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates:1958-64 1 ☐ Yes 2 XNo Specity: þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) Coflege (1-4or 5+) Administration Office Clerk 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Funk Lillian Volke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elaine Funk (Wife) 7755 Eastdale Road Baltimore, Maryland 21224 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Maryland 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cardiomyopathy 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Tonknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12/3/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

31. Date filed (Month, Day, Year)

DEC 0 6 2007

Registrar's Signature

ma

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year 200 vankou reorge 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Medical of Maryland mere 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 **☑** M 2 □ F 68 Oct 4, 1939 Maryland 212-34-8124 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2 No Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 601 S. Charles Street 21230 USA 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) repairman computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19a. Informant's Name/Relationship (Type. Print) 19h. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Alice Bellamy/Comm on Aging 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state <sup>22. Name and Address of Facility</sup> State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Meumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery Month Day Year acco use contribute to the cause of death? 2 No 3 Probably 4 Minknown

Physician /Medical **Examiner** 

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

**Physician** 

/Medical

Examiner

10a. State

unk

Director

Funeral

Completed by

Be 2

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 Is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

burial-tra attending physician for use as the buria ed by the a detached for s been signed by the should be detached cate has, certificate director, After this funeral dir

law requires that the death certificate be executed

the Hospital or Attending Physician:

within 24 hours arter ucc....

To the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760

Physician/Medical Examiner

Completed by

Be

٩

Certification:

Medical

	d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 □Ectopic		
Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part I.	. 23e. Did toba
				24a. Was an autopsy perform
25. Was case referred to medical			26. Place	of Death (Check only one
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ [	OOA Other: 4 Nu	rsing Home 5 🗆 Resider
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe hov

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

	autopsy performed? 1∐ Yes 2∭00	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
26. Place of Dea	th (Check only one)	
her: 4 \Bursing H	ome 5 Residence	G □Other (Specify)
uryat ork? ]Yes 2 ∐No	28d. Describe how injur	y occurred
•	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )

29a.	Certifier
	(Check only
	one)

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

24h Were autopsy findings available

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

DEC 0 6 2007

Registrar's Signature

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature				1 - For State Registrar	State of M	aryland /		artment of H		nd Mental Hy	giene Reg. No.	007	390	13
Addition Framework Framewo		Physici	an							Month	Day			
Revenuoud Nursing 6 Rehab Center    Commonwealth	Н	/Medic	al			1		4h City Town of	Location of					PM"
Second Section Number   0 str   10 st		Examin	er				r			Death	45. 0	yourny or Bour		
Part   Color		Funeral			S. Sex 7. A			If Under 1 Year	If Under 2		th Year)	9. Birt	hplace (State o	r Foreign
TO STATE OF THE PROPERTY OF THE COUNTY BASES OF INCREMENT OF THE C					1\\\ 2□F	39	Yrs.	Months Days	Hours					
The property of the property o		and w				10c. City, To	own or Lo	ocation					10d. Inside Ci	ty Limits
The property of the property o		f sho	ō	MD		Ba1	time	ire					1 Yes	2 🗆 No
The property of the property o		r 28a-	rect				CIM				10g. Citiz	en of What Co	ountry?	
The property of the property o		h with	ai D	501 W. Frank1:	in Street			2	1201			USA		
The property of the property o		ems	ner		12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	D- 1-			
The property of the property o	36	s afte			If Yes, Give	.No		1 □ Yes 21X No	Specify:			Specify:	black	
The property of the property o	8	thour	edt	15. Decedent's	Education	16	Sa. Dece	dent's Usual Occup	ation	unk	16b. Kin	d of Business/	Industry	unk
The property of the property o	215	hin 72 an "ne Medi	plet			5+)	(Give life.	kind of work done of DO NOT use retired	during most I)	of working				
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Part	2	ad wit	Соп											- 1
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Part	pu	be filk	Be	17. Father's Name (First, Middle, La	ist)			unk	18. Mother	's Name (First, Middle	, Maiden S	Sumame)		unk
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as sarriage or respiratory arrest.    Committee   Course   C		hould d Mer narke natic	2	10a leformant's Nama/Ralationshi	o (Tugo Print)	11	Ob Mailie	an Address (Street	and Number	r or Rural Boute Numb	er City or	Town State	Zin Code)	
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Part	<u>⊠</u>	nd 2 s lth an 27 Is i									-			
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as sarriage or respiratory arrest.    Committee   Course   C	ē,	s 1 ar f Hea item other	. 8	20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	ea)	Date	20c. Loc	ation - City or	Town, State	
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Part	Ë	Page Jent o Int: If				,	,,							
23a Part Enter the classes, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Part	alti	epartn sports sports iy inju		21. Signalure of Funeral Sectice Li Ronal S			3	Name and Address	Soft Facility	Soard 655 W	. Bal	ltimore	Street	:
Securinary   Sec	-	20599		Jun 11	Mell									
The property of the property	Н			shock or heart failure. List of			o not en	ter the mode of dyin	g, such as o	ardiac or respiratory a	irrest,		Interval Bet	ween
Secuentially list conditions.  Sequentially list conditions.  Due to (or as a consequence of):  Du	ı			disease or condition	_ a	2098	VIL.	e De	hn					
The contraction of the contracti	П				Due to (or as	s a contequenc	(Xe of):		100	V1	TA A			
The contraction of the contracti			Je.	Sequentially list conditions,	b. Sue to (or a	a consequenc	e of):	THE WING	Con la	our r	. ~ >			
State		cuted nd ransit	amir	that initiated events		80170	2						N.	- 4
FFEMALE   23b. Was discedent pregnant in the past 12 mogths?   1   1   1   1   1   1   1   1   1	Ö,	e exe dan al urial-1	EX	resulting in death) Last	Due to (or as	s a cons o end		en ti	h - 1					
State   Stat	876	cate b	dica		d	The part of the pa			mon	3070				
State   Stat	×6	certifi Iding I Ise as	/Me		23c. If yes, outcom-	e of pregnancy					2:	3d. Date of de	livery	
State   Stat		death atter	ciar	in the past 12 months?	4 ☐ Pregnant a									Year
STACE    State   State	o.	the by th ache	hysi		9□ Unknown									
The state of the s		es tha gned		Part II. Other significant condition	s contributing to death	but not resulting	g in the u	nderlying cause giv	en in Part I.					
The state of the s	ord	equir sen si lould I								1	Yes 2L			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	ec	G 22 CV	npie							auto	psy	24b. Were at prior to	utopsy findings completion of c	available ause of
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	E H	Th ate pag	ပ်							1 ☐ Yes	2 <b>□</b> No	1 ☐ Yes	2 □ No	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Zi.	sicien certif rector	8	examiner? /	Hospital:	o 🗆 sp.	0	Oth		2		—		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	of	Physer this eral di	$\vdash$	27. Manner of Death			o. Time o	f 28c, Injur	y at				City)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	ion	nding ath. r: Atte	atio	1		ay rear)	injury			lo				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Vis	r Atte er de: recto by th	tific	determin	ed 200. Place of Ir		, farm, st	reet, factory, office					ural Route Num	nber,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHOALIS A. HASHMI 821 W. ENTAW ST SINGLE 308, BALTIMORE MD 21201  State 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year)	ā	ital or urs att rel Di	Cer											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHOALIS A. HASHMI 821 W. ENTAW ST SINGLE 308, BALTIMORE MD 21201  State 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year)		Hosp 24 hou Fune tely til	lical	(Check only 2 Medical E.	xaminer: On the basis	of examination								5)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHOALIS A. HASHMI 821 W. ENTAW ST SINGLE 308, BALTIMORE MD 21201  State 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year)		o the ithin 2 o the omple	Med		and manner s	tated.		29c. Licens	e number		29d. Date	signed (Mont	th. Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SHOAIJ3 A. (HASHM) 821 W. ENTAN STEME 308, BALTIMORE MD 2120)  State 31. Date filed (Month, Day, Year)  82. Registrar's Signature		F 3 F 8			aux		MID	D	314	64	1.1	1301	107	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				30. Name and address of person w	ho completed cause of	death (Item 23a	а) (Туре,			-	^	1		2120
orane					J			IN ST.	Int	304',B	4LT	MORE	MD.	-1601
						trar's Signature	ho	le le						

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:15 AM ISADORE FELLER December 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunai Hospital 94 Baltimore N/A Baltimore Cuty If Under 1 Year | If Under 24 His 8. Date of Birth (Month, Day Year 11/21/1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 **№** M 2 🗆 F Hours Min. 579-01-0467 NJ 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show odeal Examiner must be notified at BALTIMORE MD OWINGS MILLS 1 ☐ Yes 2 No Director 10f Zip Code 10g, Citizen of What Country? 10e. Street and Number 9773 GROFFS MILL DRIVE U.S.A. 21117 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married WHITE Maryland 21215-0036 1 □ Yes 2 🕅 No Specify. Completed by 1 and 2 should be filed within 72 hours a Health and Mental Hygiene. 3 Widowed 4 □ Divorced ear or Dates 7 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALES PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **FELLER** FANNIE GLASS MORRIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: if Item 27 is n RUTH CERRETA / DAUGHTER 8040 UPPERFIELD LANE - OWINGS MILLS, MD 21117 Baltimore, permit. Pages 1 ar Department of Hea Important: if Item 3 any injury or other 20a. Method of Disposition 20c. Location - City or Town, State OHEB SHALOM PARK 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/05/2007 OWINGS MILLS, MD SOL LEVINSON & BROS , INC. 21. Signa of Funeral Service Licenses 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4 days Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for an a c Examiner the death certificate be executed Due to (or as a consequence of) physician ar Physician/Medical as 1 attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by upper 91 bleeding 1 Yes 2 No 3 Probably 4 Unknown Acute Renal failure 24a. Was an autopsy performed?
1□ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? page 25. Was case referred to medical examiner? 21**X** No certificate 1 ☐ Yes To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🖍 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier  $\mathcal{W}$  WD PAS# 19434-000 December 2, 2007 ess of person who completed cause of death (Item 23a) (Type, Print) Anupama DoraisWamy sinai Hospital of Baltimore , MD 31. Date filed (Month, Day, Year)
DEC 6 2007 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Item 28e per dr., 8874, 12/06/07dhb Registrar 20b per fh Certificate of Death	lental Hygi	iene 9. N2 0 0 7 3 9 0 1	5
		31	Decedent's Name (First, Middle, Last)	2. Date of Death	h 3. Time of Deat	.h
3	Physic /Medi		James William Glenn	Month	Day Year   1330-415	М
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
			5300 BOW LOYS LA DOTC BALTMORE			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthplace (State or Fore	eign
3	Director		216-34-600 Yrs.	Mar 31	1941 Maryland	,
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Lin	nits
	f ehc	ō	MD MA Battemore City		1 <b>%</b> Yes 2 □	
	28°	rect	10e. Street and Number	10	0g. Citizen of What Country?	
	3a of	ā	5300 Bowleys lane Apt C 21206		USA	
	me 2	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - American Indian,	
9	after or ite		1 Ney Married 2 Married 1 Yes 2 No	Rican, etc.)	Black, White, etc.	
5-0036	72 hours after death with the Maryland natural', or iteme 23a or 28e-1 ehow discal Exarturet se multified at	l by	3 Notidowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: Black	
5-0	72 h	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	ina .	16b. Kind of Business/Industry	
21	within ene. then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	9	+ + + '	
121	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	(F)	Transportation	-
anc	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event.	Be	,		~	
Ž	d Mei rark ratic	2			Pavis	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygene. If Item 27 is marked other then "natural", or iteme 23a or 28e-f show or other traumatic event, the Medical Exarturar ermust ke nutified at			_	1 1 1 - 1	
347	of Health of Hea	1	20a. Method of Disposition 20b. Place of Disposition (Name of		tomu 21 206 20c. Location - City or Town, State	
Baltimore,	Pages nent of I		1 🗆 Burial 2 🕏 Cremation 3 🗆 Removal from State   cemetery, crematory or other place) 12/01	1/07	01 11	
臣	perriit. Page Department c Important: If any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility.	31 501 (	Cateneville, MD	
Ba	perritt. Page Department of Important: If any injury or once.		Revald a Frager 2701	ysu	Bulling 2122	2
W.	. 34		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	or respiratory arre		7
			snock, or near tailure. List only one cause on each line.	/ - 1	Interval Between Onset and Death	ı
4	Physician /Medical		disease or condition resulting in death)  a. /SCHOMIC HOAN	W150	CASE	
	Examiner		Due to (or as a consequence of):		and the same of th	
4				- 10/	Aller 18 5 34-	2.04
		ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	WAL	Wiscons 3701	4RS
	uted d ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts)	WAL	Chisonse 3/el	4RS
oʻ.	executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):	WAL	Clisons 37er	425
,092	te be executed ysician and ie burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause) cause (Disease or injury cause) (Disease	WAL	Disense 37er	4,25
68760,	rtificate be executed ng physician and as the burial-transit	dicai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C	WAL	Oisons 3701	485
	th certificate be executed lending physician and r use as the burial-transit	dicai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant	WAL	23d. Date of delivery	4,2,5
	death certificate be executed are attending physician and ed for use as the burial-transit	dicai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Ves 2 No	WAL.		4,85
	at the death certificate be executed by the attending physician and stached for use as the burial-transit	dicai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  23c. If yes, outcome of pregnancy  1	WAL.	23d. Date of delivery	4,85
	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		23d. Date of delivery  Month Day Year  pacco use contribute to the cause of death?	4,2,5
	equires that the death certificate be executed sen signed by the attending physician and fould be detached for use as the burial-transit	by Physician/Medical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  23c. If yes, outcome of pregnancy  1		23d. Date of delivery  Month Day Year  pacco use contribute to the cause of death?	
	aw requires that the death certifi as been signed by the attending 2 should be detached for use as	by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	23e. Did tob 1 □ Ye 24a. Was ar	23d. Date of delivery  Month Day Year  pacco use contribute to the cause of death?  ps 2 No 3 Probably 4 Unkno	wn ——able
Records, P.O. Box 6	The law requires that the death certify ate has been signed by the attending bage? should be detached for use as	by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	23e. Did tob 1 ☐ Ye  24a. Was ar autops; perform	23d. Date of delivery  Month Day Year  Dacco use contribute to the cause of death?  Solve 2 No 3 Probably 4 Unknown  24b. Were autopsy findings availating prior to completion of cause death?	wn ——able
Records, P.O. Box 6	The law requires that the death certify ate has been signed by the attending bage? should be detached for use as	e Completed by Physician/Medical Examin	if any, leading to imendiate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):    Due to (or as a consequence of):	23e. Did tob  1  Ye  24a. Was ar autops perform 1  Yes 2	23d. Date of delivery  Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  1   Yes 2   No	wn ——able
Vital Records, P.O. Box 6	The law requires that the death certify ate has been signed by the attending bage? should be detached for use as	Completed by Physician/Medical Examin	if any, leading to inderdiate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C	23e. Did tob  1  Ye  24a. Was are autopsy perform 1  Yes 2	23d. Date of delivery  Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  1   Yes 2   No	wn ——able
of Vital Records, P.O. Box 6	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	To Be Completed by Physician/Medical Examin	if any, leading to inderdiate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C	23e. Did tob  1  Ye  24a. Was are autopsy perform 1  Yes 2	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availa prior to completion of cause death?  1 Yes 2 No e)	wn ——able
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  25. Was case referred to medical examiner? 110 Yes 2   No 27. Manner of Death 1   Natural 5   Pending 2   Accident in evestigation   Part to (or as a consequence of):  23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death   5   Other (specify)   9   Unknown   1   Live birth 2   Petal death   5   Other (specify)   9   Unknown   1   Live birth 2   ERVOutpatient 3   DOA   Other: 4   Nursing Hore   Nursing Hore	23e. Did tob 1	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availa prior to completion of cause death?  1 Yes 2 No e)	wn ——able
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.    FFEMALE:	23e. Did tob  1	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  1 Yes 2 No  e)  ince 6 Other (Specify)  w injury occurred	wn ——able
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	Due to (or as a consequence of):   Cause   Chief Underlying   Cause (Disease or injury that initiated events resulting in death) Last	23e. Did tob  1	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  1 Yes 2 No  e)  Ince 6 Other (Specify)  w injury occurred  reet and Number or Rural Route Number,  State)	wn ——able
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25b. Was case referred to medical examiner? 1   Yes 2   No 9   Unknown  26c.   Due to (or as a consequence of):  d.  27c.   Due to (or as a consequence of):  d.  27c.   Due to (or as a consequence of):  d.  27c.   Due to (or as a consequence of):  Due to (or as a consequen	23e. Did tob  1  Ye  24a. Was ar autopsy perform 1  Yes 2 n Check only one me 5  Reside. 28d. Describe ho  28f. Location (Str. City or Town,	23d. Date of delivery Month Day Year  acco use contribute to the cause of death?  as 25 No 3 Probably 4 Unknown  24b. Were autopsy findings availated?  acco use contribute to the cause of death?  24b. Were autopsy findings availated prior to completion of cause death?  1 Pes 2 No  acco use contribute to the cause of death?  24b. Were autopsy findings availated prior to completion of cause death?  1 Pes 2 No  acco use contribute to the cause of death?	wn ——able
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	Due to (or as a consequence of):   Cause   Chief Underlying   Cause (Disease or injury that initiated events resulting in death) Last	23e. Did tob  1  Ye  24a. Was ar autops; perform  1  Yes 2  1  Check only one  me 5  Reside. 28d. Describe ho  28f. Location (Str. City or Town.) and due to the caed at the time, da	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  25 No 3 Probably 4 Unknown prior to completion of cause death?  1 Yes 2 No  1 Yes 3 No  1 Yes 3 No  1 Yes 4 Number of Rural Route Number, 1 Yes 3 Number, 1 Yes 3 Number of Rural Route Number, 1 Yes 3 Number of Rural Route Number, 1 Yes 3 Number of Rural Route Number, 1 Yes 4 Number of Rural Route Number, 1 Yes 5 Number of Rural Route Number, 1 Yes 6 Number of Rural Route Number, 1 Yes 6 Number of Rural Route Number, 1 Yes 7 Number of Rural Route Number, 1 Yes 1 Number of Rural Route Number of Rural Rural Rural Rural	wn ——able
on of Vital Records, P.O. Box 6	ding Physician: The law requires that the death certif. h. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):    Due to (or as a consequence of):	23e. Did tob  1	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availation of cause death?  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  24b. Were autopsy findings availation of cause death?  1 Yes 2 No  25 No  26 Other (Specify)  27 Year and Number or Rural Route Number, State)  28d. Date signed (Month, Day, Year)	able of
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	Due to (or as a consequence of):    Continuous	23e. Did tob  1	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  25 No 3 Probably 4 Unknown prior to completion of cause death?  1 Yes 2 No  1 Yes 3 No  1 Yes 3 No  1 Yes 4 Number of Rural Route Number, 1 Yes 3 Number, 1 Yes 3 Number of Rural Route Number, 1 Yes 3 Number of Rural Route Number, 1 Yes 3 Number of Rural Route Number, 1 Yes 4 Number of Rural Route Number, 1 Yes 5 Number of Rural Route Number, 1 Yes 6 Number of Rural Route Number, 1 Yes 6 Number of Rural Route Number, 1 Yes 7 Number of Rural Route Number, 1 Yes 1 Number of Rural Route Number of Rural Rural Rural Rural	able of
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical Examin	Due to (or as a consequence of):    Continue   Continue	23e. Did tob  1  Yes  24a. Was are autopsy perform 1  Yes 2  1  Check only one me 5 Resider 28d. Describe ho  28f. Location (Str. City or Town, dand due to the caed at the time, dand street ti	23d. Date of delivery Month Day Year  Pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  1 Yes 2 No  Pacco use contribute to the cause of death?  1 Yes 2 No  Pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  1 Yes 2 No  Pacco use contribute to the cause of death?  24b. Were autopsy findings availating prior to completion of cause death?  24b. Were autopsy findings availating prior to completion of cause death?  24b. Were autopsy findings availating prior to completion of cause death?  25c. No  24b. Were autopsy findings availating prior to completion of cause death?  25c. No  24b. Were autopsy findings availating prior to completion of cause death?  25c. No  26c. No  27c. No	able of
on of Vital Records, P.O. Box 6	iing Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Medical Examin	Due to (or as a consequence of):    Continue   Continue	23e. Did tob  1  Yes  24a. Was are autopsy perform 1  Yes 2  1  Check only one me 5 Resider 28d. Describe ho  28f. Location (Str. City or Town, dand due to the caed at the time, dand street ti	23d. Date of delivery Month Day Year  pacco use contribute to the cause of death?  24b. Were autopsy findings availation of cause death?  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  24b. Were autopsy findings availation of cause death?  1 Yes 2 No  25 No  26 Other (Specify)  27 Year and Number or Rural Route Number, State)  28d. Date signed (Month, Day, Year)	able of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,26,28c per dr. 28/4,12/06/07dhb State of Maryland / Department of Health and Mental Hygiene 25,26,28c per dr. 28/4,12/06/07dhb Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last)
CATHERINE M. GOODWIN Day Month **Physician** 6:32A M NOV. 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/ABALTIMORE CITY SINAI HOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕱 F Months 91 217-18-9750 12/12/1915 MARÝLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show ner must be notifled at 1 XYes 2 □ No BALTIMORE CITY N/AMD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 4412 ELDERON AVENUE "natural", or Items 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes Who If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: ģ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the DOMESTIC 12 HOUSEKEEPER s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ANNIE TORRENCE JOHN LITAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GRANDpermit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any Injury or other trau once. CATHY A. JACKSON/ 4412 ELDERON AVE., BALTIMORE, MD 21215 DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
MT. CALVARY CEM. XXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) BROOKLYN, AA CO, MD 11/30/07 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Euneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, 23a. PALE ter the discusse, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, so fixed the cause (Final disease or conditions). Approximate Interval Between Onset and Death and stage Algheimers Demant 4 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of)  $\mathcal{IH}_{\alpha}$ ,  $\mathcal{IS}$ ,  $\mathcal{IG}$ Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4⊟Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours afte To the Funeral Dis ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00057465 12 Sleyapuhuemo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. Ruy wpart M.D. 25 Main St., In the 200, Reisterstown, MD. 21136

Registrar

State

Sopolicia, Cathaine

31. Date filed (Month, Day, Year)

				se Type or Prin									le.		
			For State Registrar	Oldio of Mi	ar y rarra	-	tificate of				Reg. No		7	20	01-
		9	Negistral     Decedent's Name (First, Middle,	Last)					2	2. Date of De	eath	201	<del>)  </del>	3. Time	of Death
1	Physici		Ca	arolyn M	1. (	Groch	owski			Month Novem	ber	<sup>19</sup> 23 <b>,</b> 20	007	3:2	3 P M
1	/Medic		4a. Facility Name (If not institution,				4b. City, Town,	or Location of	of Death		40	. County of	Death		
			Lorien of Be	lair				lair						d Co.	
ţ.	Funeral		5. Social Security Number	6. Sex 7. Ag 1  M 2  F	e (In yrs. last		If Under 1 Year Months Days		24 Hrs. 8 Min.	B. Date of Bir (Month, Da	rth a <i>y, Y</i> ea <i>r</i>	) !	9. Birthp Cour	lace (State atry)	or Foreign
н	Director		217-16-5457	70 W 2001	85	Yrs.			1	March	10,1	1922	Ma	rylan	d
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation						1	0d. Inside	City Limits
	f sho	ō	Maryland	Baltimore				Dι	undal	ζ				1 □Ye	s 2 <mark>™</mark> No
	the 28a- notif	rec	10e. Street and Number				10f. Zip Code				10g. C	itizen of Wh	at Cour	ntry?	
	72 hours after death with the Maryland 'natural', or Items 23a or 23a-f show disal Examiner must be notified at	Funeral Director	1756 Stengel	Avenue				21222			Ur	nited	Sta	tes	
	ms 2	ner	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of Yes, specify Cul		igin? (Spec	ify Yes or No		14. Race -		an Indian,	
9	after or Ite	3	1 ☐ Never Married 2 ☐ Marrie				☐ Yes 2☐XNo			ouri, oto.,		Specify:		hite	
21215-0036	iral", Exa	d by	34 Widowed 4 □ Divorced	Year or Dates:											
2-(	72 h "natu dical	ete	15. Decedent' (Specify only highes	s Education t grade completed)	1	16a. Deced (Give I	ent's Usual Occu kind of work done O NOT use retire	pation during mos	st of working	7	16b. I	Kind of Busi	ness/in	dustry	
12	within sne.	Completed	Eiementary/Secondary (0-12)	College (1-4or 5	5+)			50)				Own H	Jomo		
2	Hygie Ther int, th	ပ္	7 Years 17. Father's Name (First, Middle, L	ast)		HOI	nemaker	18. Mothe	er's Name (	First, Middle	, Maide				
an	d be	o Be	Frank Gross	•				Ma	argare	et Mue	llei	2			
Maryland	2 should be and Mental is marked craumatic ever	ို	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Stree						tate, Zij	Code)	
	nd 2:		Cheryl F. Fost	ter (Daughte	er)	903	South P	ine R	idge (	Court	Be]	L Air,	MD	210	14
ľe,	f Heg		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of natory or other pla	ace)	Da	te	20c. L	ocation - C	ity or T	own, State	
E O	Page lent o nt: If		1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp				. of Je	1	em. 13	1/28/2	007	Dur	ndal	k, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	0	22	Name and Addr Ouda-Ruc	ess of Facili	ity	Jome o	f Di	ındə 1k	т Т	nc	
<u> </u>	9 <b>3 1 8</b>		deredor	E. Ken		- 7	922 Wis	e Ave.	Dur	dalk.	Mar	yland	21	222	
), (0	Physician / Medical Examiner pnual-transit	l Examiner	23a. Part1. Enter the disease of shock, or hear failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		rovasc a consequer a consequer	nce of):	Acciden							Approxim Interval B Onset an	etween d Death
.O. Box 6876	death certificate e attending phys d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnan Other (specify)	су				23d. Date Mont		ery Day	Year
S,	s tha	by P	Part II. Other significant conditio						l.			use contrib		3.7	
ord	equire en siç ould b	ed	Hypertension,	Atrial Fibr	illati	ion, I	Iypothyr	oid		1	Yes	2 □ No 3	Pro	bably 44	Unknown
Vital Records,	2 38	Completed								24a. Was	opsv	24b. W	ere auto	opsy finding impletion o	gs available f cause of
<u>=</u>		50								peri 1⊟ Yes	ormed? 2 ☑ N	lo 1	ath? Yes	2 □ No	
/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	Heavital:			10			(Check only					
7	ys dil	ို	1 Yes 2 No	Hospital: 1 Inpatie		R/Outpatien 8b. Time of	3 DOA			e 5□Res 3d. Describe				fy)	
N C	After Arter funera	<u></u>	27. Manner of Death  1X Natural 5 □ Pending	(Month, Da		Injury	28c. Inj W	urya≀ ork? ∐Yes 2. □		od. Describe	r now inj	ury occurre	u		
Division or	Attending r death. ector: After oy the fune	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be 290 Place of ini	ury - At home	e, farm, stre				3f. Location	(Street a	and Number	r or Rur	al Route N	umber,
<u>&gt;</u>	after after Direct d in by	ertif	4 ☐ Homicide determi	building, et	tc. (Specify)	, ,	,			City or To					
_	Hospita 4 hours Funeral tely filled	Medical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Examiner: On the basis of and manner st	of examination	edge, death n and/or in	occurred at the estigation, in my	time, date a opinion, de	nd place, a eath occurre	nd due to the	e cause( e, date a	s) and man	ner as s	stated. to the caus	e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1/10			29c. Licer	nse number			29d. D	ate signed	(Month	Day, Year	)
			•	Midlie	tu i	MD	D45	344			11	(23/	7-0	07	
	6		30. Name and address of person								,				
	<i>D</i>	to.	Suresh Dhanjar	i, M.D. 622		Unio	n Ave. I	lavre	De Gr	ace, 1	Mary	land	210	78	
	Regist		DEC 0	6 2007		1									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Olive Marie George 29,2007 November /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Fairhaven Retirement Community Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2√2 F Director 213-12-9158 87 Jan. 4,1920 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Directo Maryland Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7200 Third Avenue 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatte event, the Medical Examine. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur McKenzie Anna F. Dawson မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Suite 109 Wayne George (Son) 2606 Chapel Lake Drive Gambrills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 12/3/2007 ◆□Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Moreyia /Medical Due to (or as a consequence of): erebrovascular disease Examiner Sequentially list conditions Examiner If any leading to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit pertension Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown signed by the at d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrullation. 2 No 3 Probably 4 ☐ Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

5:05

10d. Inside City Limits

White

1 ☐ Yes 2\(\text{XNo

21054

Approximate Interval Between Onset and Death

Year

Day

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1645 Jan 1am Registrar's Signature State Registrar

29b. Signature and title of Certifive

29c. License number

Gaston, Jr.

4b. City, Town, or Location of Death

2. Date of Death

Day

4c. County of Death

December 4, 2007

3. Time of Death

4:10pm M

			Gilchris	t Cente	r				Tows	on			Baltin	nore	
	Funeral		5. Social Security N		6. Sex	7. Age (In	yrs. last birthda	/) If Under Months		If Under 24 Hours	Hrs. 8	Date of Bi (Month, D	rth av. Year)	9. Bi	rthplace (State or Foreign country)
-	Director		215-16-18	310	1 <b>∑</b> M 2□F	87	7 Yrs.	World	Dujo	. 100.10		July :	30,192	0 M	aryland
	D		Usual Residence of												T
	ylan ylan ylan		10a. State	10b. County		100	c. City, Town or	_ocation							10d. Inside City Limits
	Mar-f st	to	Maryland	Ra1t	imore		Towso	n							1 ☐ Yes 2 No
	the 28a	Director	10e. Street and Nur		- Imor c		10,00	10f. Zip	Code				10g. Citize	n of What C	ountry?
	with la or t be		FFF 17-1	1 174 -	Dood				212	96			1	USA	
	eath	Funeral	11. Marital Status	lley Vie	12. Was De	cedent Ever	in U.S. 13	I. Was Dece If Yes, spe			n? (Specif	y Yes or N		. Race - Am	erican Indian,
	iten iten iner	들	1 Never Marri	ied 267 Marrie	Armed F	Forces?		If Yes, spe	cify Cubar	n, Mexican,	Puerto Ri	can, etc.)		Black, Wh	ite, etc.
36	rs af r, or	by	3 ☐ Widowed	21	If Yes, G Year or	aive		1 ☐ Yes	2 💢 No	Specify:			S	pecify:	hite
Ş	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show kdical Examiner must be notified at	be		15. Decedent'	s Education	_	16a. Dec	edent's Usu	al Occupa	ition			16b. Kind	of Busines	
7	"na"	lete		cify only highes	grade completed		I (Gi	e kind of wo	rk done d	urina most d	of working		Î		•
12	d within 72 ho giene. r than "natur the Medical.	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5+) 01		esign Engineer					Aeron:	autical	
2	other (	ပိ	17. Father's Name	(First Middle I	act)	UI	Desi				s Name (/	First. Middle	e, Maiden St		ideleal
ũ	e graph	Be		_			0					,	_		Waring
<u>×</u>	should be nd Mental marked o	ဥ	Robert		tterson		Gast				lian		Rebe		
Maryland 21215-0036	2 sho and is ma		19a. Informant's Na					•	•				-		
	1,2 mg		Mary Lou	ise Gas	ston/Wife		555 Valley View Road, Towso					1		21286	
Sre	iges 1 a nt of Hea i if item or othe		20a. Method of Disposition 1		20b. Place of Dispos cemetery, crem		position (Nar rematory or d	position (Name of matory or other place)  Dec 12, 2007			20c. Loca	ition - City o	r Town, State		
Ĕ	Page tment tant: It					M	aryland	Veter	ans	1				ison,	Maryland
Baltimore,	permit. Pag Department Important: I any injury c	1	21. Snine vi L	4 Donation 5 Other (Specify)			-	22. Name ar	nd Addres	s of Facility		5 D	1	aney Valley Inc.	
ä	permit. Departimonts imports any inj once.		Rry	in W. C.		100	l.	Lemmon 10 W.	Pado	eral B	Home	Timor	ilaney	MD 21	ino3
	5-3-56		23a Part1 Enter t	he disease, or i	complications that	caused the									Approximate
			shock, or hea		only one cause or	each line.									Interval Between Onset and Death
	Physician		disease of condition resulting in death)	Pilai	_a/50	chem.	nsequence of):	hongo	pata	74					years
	/Medical Examiner		rodding in dodairy												
-	LAdillille	_	Sequentially list co	nditions,	b										
\	P #	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	Due to	o (or as a co	consequence of):								
14	be executed sician and burial-transit	аш	Cause (Disease or that initiated events	S	С										
Ö	an a	Ĕ	resulting in death) I	Lasi	Due to	Due to (or as a consequence of):									
68760,	ate be shysici the bu	cal			d										
99	tifica ig ph as th	led													
Box	th certifi tending r use as	2	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, o	utcome pf p		B □Ectopic p	regnancy				23	d. Date of d	
œ	deatl	icia	in the past 12 1 ☐ Yes 2 [		4□Pre	gnant at time		Other (s						Month	Day Year
P.0	uires that the death certificate signed by the attending phys d be detached for use as the	by Physician/Medical	9 ☐ Unknown		9□Unk	nown						_			
σ.	that led b deta	P	Part II. Other signi		ns contributing to	death but no	ot resulting in the	underlying o	ause give	n in Part I.		23e. Did	tobacco use	e contribute	to the cause of death?
ds,	sign d be	d b	Chrinic	: Obsh	Warr	nvim	may	descas	9			15	Yes 2□	No 3□	Probably 4 ☐Unknown
Ö	w requir been s	Complete				1						240 18/0	0.00	24h Moro	autoney findings available
ě	The law req ite has been bage 2 shou	du	_								<del></del>	24a. Wa	opsy formed?	prior to	autopsy findings available o completion of cause of ?
=		S										1□ Yes		1 ☐ Ye	s 2 No
it a	Physician: The law this certificate has be ral director, page 2 s	Be (	25. Was case referexaminer?	rred to medical							of Death (	Check only	one)		
7	nis ce dire	70	1  Yes 2 2 1	No	Hospital: 1	] Inpatient	2 ☐ ER/Outpat	ent 3 □ D	OA Othe	er: 4 🗆 Nurs	sing Home	5 Res	sidence 6	Other (Sp	ecify) MOSPICE
0	ding Phy. After thi		27. Manner of Deat		/A 4m	e of Injury onth, Day Ye	28b. Time	of	28c. Injury Work	at ?	28	d. Describe	how injury	occurred	
Ö	nding ath. r: After e funei	atio	1 🔯 Natural 2 ☐ Accident	5 Pending investig	ation	,,		M		∕es 2□N	0				
Division or Vital Recor	Attending r death. ector: After by the fune	fic	3☐ Suicide 4☐ Homicide	6 ☐ Could n determi	200.1100	ce of injury - Iding, etc. (S	At home, farm,	street, factor	y, office		28		(Street and own, State)	Number or i	Rural Route Number,
Di	i g fe o	Certification:	4 Unomicide		Duli	runiy, etc. (c	poony)					Only Of 1	Jim, Diale)		
	ospital hours a uneral t	alC	29a. Certifier	1 Certifying	Physician: To the	he best of m	y knowledge, de	ath occurred	at the tim	ne, date and	place, an	d due to th	e cause(s) a	nd manner	as stated.
	0-3-	63	(Check only	2   Modical i	-vaminar. On the	nacie of exa	amination and/or	investigation	n in my oi	omion, deaf	D OCCULTER	at the time	<ul> <li>date and n</li> </ul>	nace, and d	ue to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON J. CHARLES MA

6701 N. Charles ST Dowsons MD 21204

9+1 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1. Decedent's Name (First, Middle, Last)

Patterson

4a. Facility Name (If not institution, give street and number)

Robert

Physician

/Medical

DEC 0 6 2007

32 Registrar's Signature

07-09345	***	Please Type of	or Print in Black In	delible lnk.	Ensure All	Copies Are Le	egible.	7 0000
Dorothy Garrett-Sn		State or State	of Maryland / Depa	rtment of He <i>tificate of De</i>		ntal Hygiene	200	7 3902
Dhominian	Regis			uncate of De	au 1	2. Date of De	Reg. No.	3. Time of Death
Physiciana Medical Examine			arrett-Smit	th			Day Year er 2, 2007	1940 hrs
	4a. F	acility Name (if no institution, give			y, Town, or Location		4c. County of Death	
	L	University Hospital I.C.U		Ва	ltimore		N/A	
Funeral	5. Sc	ocial Security Number 6. S	ex 7. Age (In yrs. la				Ecroia	hplace (State or
Director	101	64-40-0200 1	M 2XF 74	Yrs. Mo	nths Days Hou	rs Min. 7-7	-1933 Col	intry) Carolina
	Usua	al Residence of Decedent						
w any	10a.	State 10b. County		Town or Location				10d. Inside City Limits 1 Yes 2 No
f sho		V.Y. Nassi	au Uh	iondal				
ne Maryland or 28a-fshow any fied at once.	10e.	Street and Number	<b>\</b> .	10f.	Zip Code		10g. Citizen of What Cour	itry?
er death with the Maryland or items 23a or 28a-f sh must be notified at once	5 /	31 Martin	Drive		11553			- Indian Black
ath with the items 23a ast be noti	2 11. N 2 1 1	Marital Status  Never Married 2 Married	12. Was Decedent Ever in U.  Armed Forces?			origin? ( Specify Yes or N an, Puerto Rican, etc.)	White, etc.	can Indian, Black,
er dez			1 Yes 2 No	1 Vec	2 No speci	fv.	Specify: Bla	ck
urs aft		. Decedent's Education (Specify o	or Dates:	-		ve kind of work done	16b. Kind of Business/I	
72 hor "" al Exa		lementary/Secondary (0-12)	College (1-4 or 5+)	-	working life. DO NO		. , .	
5-0036 ed within 72 hour lygiene. other than "natu	<u>ā</u>	12		Se(-	f Emp	loyed ner's Mame (First, Middle	Cateria	29
Hygie other	3 17. F	Father's Name (First, Middle, Last			18.Moth	ner's Mame (First, Middle	, Maiden Surname)	/
121. I be fill ental I went,	8 <u> </u>	Theodore	Coleman			ssie		
Baltimore, MD 21215-0036  Department of Health and Mental Hygiene, Import of Health and Mental Hygiene, Important of Health and Mental Hygiene, Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Commisted by Funeral Director	19a.	. Informant's Name/Relationship (	arrett	19b. Mailing Addr	ess (Street and N	Himo / C	umber, City or Town, State	, Zip Code) //996
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	20a.	are n A. 6.  Method of Disposition		Place of Disposition (			20c. Location - City or	Town, State
Ore ges l t of H	1 [	Burial 2 Cremation 3	Removal from State	crematory or other pla	ace)	1 2 2 2 2 2	11 4	15.11 usca
it. Paritment ritmen britains	4	Donation 5 Other Specify Sunature of Funeral Service Licer		reenfield 28 Name	and Address of Fac	ility F	Hempstead W. Service	11.9. 11000
Ba Perm Depa Imp	1	allow C. Da	lan	Carlto	My C. Don	glass truner	11. 21217	·A ·
Physician	23a.	Part I. Enter the disease, or com		. Do not enter the mo	de of dying, such a	s cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/Medical kaminer	Imm	failure. List only one cause on e nediate Cause (Final disease a	Multiple Injuries with Co	mplications				Death
xammer	or co	ondition resulting in death)	Due to (or as a consequence of	f):				
7		uentially list conditions, b ny, leading to immediate	Due to (or as a consequence of	f):				
	E caus	se. Enter Underlying Cause c.						
ecuted and transit	ever	nts resulting in death) Last	Due to (or as a consequence of	t):				
©		UNPENDED	AMENDED	<u></u>				
ox 68760, ash certificate be attending physici or use as the buring cirian/Med	IF FE	EMALE:	23c. If yes, outcome of pregi	nancy			23d. Date of deliver	у
687 certific iding i	23b.	Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal de		opic pregnancy	Month I	Day Year
Sox leath of e atter for us	os 1 [	Yes 2 No 9 V Unknow		other (	Specify)			
of the sached		II. Other significant conditions	contributing to death but not re	esulting in the underl	ying cause given in	Part I. 23e. Did	tobacco use contribute to	the cause of death?
Records, P.C. The law requires that ficate has been signed , page 2 should be deter	ò					1 1	'es 2 ✓ No 3 Prol	ably 4 Unknown
rds requi	<u> </u>					24a. Wa		itopsy findings available completion of cause of
eco ne law te has ge 2 s	Ĕ				•••		formed? death?	
Tiffica Or, pa	25. V	Was case referred to medical			26.Place of Dea	ath (Check only one)		
f Vita Physicia or this ce ral direct	ן מי	examiner? 1 ✓ Yes 2 No	Hospital: 1 / Inpatient 2	ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 Othe	r:
of of ug Ph		Manner of Death	28a. Date of Injury (Month, Day Year) Nov 21, 2007	28b. Time of Injury	28c. Injury at W		e how injury occurred r auto auto collision	
ion itendi leath. tor: .		✓ Natural 5 Pending ✓ Accident Investigat		1711 hrs	1Yes 2	V No		
Division o spital or Attending hours after death. ueral Director: After filled in by the fune	3	Suicide 6 Could not	be 28e. Place of Injury - At he		tory, office building	, etc. 28f. Location or Town	n (Street and Number or Ru , State) Millsboro, Del	aral Route Number, City
D spital hours ueral / filled	9 4 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Homicide determine	177 77 Wajbi Nbak					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring editical Certification: To Be Completed by Physician/Med	(Chei	ck only Certifying Fifysic	ian: To the best of my knowled r:On the basis of examination a	-				
To the Ho within 24 To the Fu completel	29b.	Signature and title of certifier	and manner stated.		29c. License numb		29d. Date signed (Mo	
	3	his his.	m JD		O.C.M.E.		December 4, 20	07
10	30. N	Name and address of person who	completed cause of death (Item	1 23a)	·	<del></del>	1	
1-				Penn Street, B	altimore, MD 2	1201		
State	te 31. E	Date filed (Month, Day, Year) DEC 0 6 280	32 Registrar's Signat	ire frank	,			
Registra	31	0 0 ESF	1 Company	1				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend ]	State of <b>tens 28b</b>	Maryland / Dep	artment Hincate	06/E	ealth a 7 dh Death	and M	lental Hyg	giene (	007	39(	120
			1. Decedent's Name (First, Middle, I	ast)						2. Date of Dea Month	ath Day	Year	3. Time o	
	Physici /Medio		Ruth Elizabeth	Harrisor	1					Novembe	r 5,	2007	4:25	A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g	rive street and num	ber)	4b. City, To	own, or	Location of	of Death			unty of Deat		
			Greater Baltimon			Tow If Under 1		If Under	24 Hre	8. Date of Birt		ltimon		or Foreign
	Funeral		, , , ,	Sex 1□M 2□F	7. Age (In yrs. last birthday 86 Yrs.		Days	Hours	Min.	Dec. 3	v. Year)	NY	hplace (State untry)	or r-oreigir
	Director		Usual Residence of Decedent	Λ	00					Dec. 3	1920	IVI		
	land		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside (	
	Mary	ō	MD Baltim	ore	Cockeys	7 <b>i</b> 11e							1 ☐ Ye	s 2 No
	the 288	rec	10e. Street and Number	010	00011075	10f. Zip C	ode				10g. Citizen	of What Co	untry?	
	30 of		10333A Malcolm	Circle				2	1030		USA	L		
	me 2	ner	11. Marital Status	12. Was Dece	dent Ever in U.S. 13	Was Deceder	nt of Hi	spanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	nican Indian,	
9	72 hours after death with the Maryland netural; or itsme 23e or 28e-f show disal Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married		2 <b>▼</b> No	1 ☐ Yes 2%		Specify:		, , , , , , , , ,		ecity:	white	
21215-0036	ral.		3X Widowed 4 □ Divorced	Year or Da	tes:									
5-	72 h	Completed	15. Decedent's (Specify only highest of		(Giv	edent's Usual e kind of work DO NOT use	done a	luring mos	t of work	ding	16b. Kind (	of Business/	industry	
121	within lene. then	dE	Elementary/Secondary (0-12)	College (1-	4or 5+)			,			0	Home		
	Hygie Hygie other t		12 17. Father's Name (First, Middle, La	st)	Hor	nemaker		18. Mothe	er's Nam	e (First, Middle,				
and	ntal l	Be C	Thaddeus M. Robe		•			Bess	s G.	Bishop				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28e-f show other traumetic event, the Medical Examinar trivial to notified at	5	19a. Informant's Name/Relationship			ling Address (	Street a			ral Route Numbe	er, City or To	wn, State, 2	Zip Code)	
Ma	d 2 sho		Rick Harrison/so							aguna N				
ē,	Health Health tam 27 other tr		20a. Method of Disposition		20b. Place of Disp		of			Date			Town, State	
ο̈́	Pages nent of ant: If it ary or o		X□ Burial 2 □ Chemation 3		Woodlaw	-			11/9	/07	Ralt	imore	, MD	
Baltimore	permit. Pages 1 Department of H Important: If Its:			ensee		22. Name and	Addres	s of Facilit	tv					
<b>B</b>	permit. Departn Imports	_	Lowell M. Lei	mmon	1 = 2	Lenmon	Fu	nerol	Ho	me of Du Timopiu	ilaney	Vall 2109	ey, In	C .
			23a: Part1. Enter the disease, or co	mplications that ca	used the death. Do not e	nter the mode	of dying	g, such as	cardiac	or respiratory ai	rrest,		Approxim- Interval Be	ate
	Physician		shock, or heart failure. List or Immediate Cause (Final	^		arre	4	_				2	Onset and	
	/Medical		disease or condition resulting in death)	_ a	or as a consequence of):	2011C	7 1		^			a		
- Qua	Examiner		0	, ch	romic of	os druci	tiv	ne PI	nlh	n. dis	LOAC	23		
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a consequence of):	1	1	0	12	C-10	1	ZX		
	be executed siclan and burial-transit	Examiner	Cause (Disease or injury that initiated events	c. 77	ght mu	MA	16	1	16	truc	Ure	10 En		
760,	lan a		resulting in death) Last	Due to (	or a consequence of):	france	A A A	ala	. 0 -	La Con	11 %	E.		
876	2 2 2	dicai	•	d	+ CIUDII	traun	VCC	OVI	N	10 10	7/1	Ta		
x 68	ding p	Me.	IF FEMALE:	23c If was out	come of pregnancy						5 360	. Date of de	liven	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Fetal death 3	☐Ectopic pre				Q	7 17	Month	Day	Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ ₩6 9 ☐ Unknown	9□ Unkno		LI Other (apor	C., y /				/ V			
٦.	The law requires that the death certificate be evite has been signed by the attending physician bage 2 should be detached for use as the burial	Completed by Physician/Med	Part II. Other significant condition	s contributing to de	ath but not resulting in the	underlying car	use give	en in Part I	l.	23e. Did t	obacco use	contribute to	the cause of	death?
ds	ures sign ld be	Q P	Heam Sv	noker						1 🖫	Yes 2□N	4o 3□P	robably 4	Unknown
ō	w req been shou	iete	Heavy d	rin Kev						24a. Was	an 2	4b. Were a	utopsy finding	s available
Re	The lav	m du	Track of	III							rmed?	prior to death?	completion of 2 □ No	cause of
a			25. Was case referred to medical					26 Place	e of Dea	1 ☐ Yes th (Check only o	2010	1 🗆 Yes	2 NO	
Division of Vital Records,		o Be	examiner?	Hospital:	patient 2 ER/Outpati	ent 3 DOA	Oth	96		ome 5 Resi		Other (Spe	icifv)	
ō		n: To	27. Manner of Death		of Injury 28b. Time	of 28	c. Injury			28d. Describe		ccurred		
ion	Attending r death. sctor: After by the funa	atio	t □Natural 5 □ Pending 2 ☑ Accident investiga		70 07 Unknow			Yes 2. ₩	No	fall	at	NOW	re Al	one
Vis.	Attendi	Ę	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place	of Injury - At home, farm, s	4				28f. Location ( City or To	Street and N	umber or A	ural Route No	mber.
ā	s after s afte	Cert	4 _ nomicide	Dunda	F	tome	-			Circle,	Cocke	ysvil	e, MD	J.J.III
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification;	29a. Certifier 1 Certifying (Check only one)	Physician: To the caminer: On the ba	best of my knowledge, decisis of examination and/or	ath occurred a investigation, i	t the tin	ne, date ar pinion, dea	nd place ath occu	, and due to the rred at the time,	cause(s) an date and pla	d manner a ace, and du	s stated. e to the cause	e(s)
	o the	Mec	29b. Signature and title of certifier	N		29c.	License	e number		-	29d. Date s	igned (Mon	th, Day, Year,	)
	- \		Manil	10M/21	MULLIN	1 1	>0	DI "	963	37	111	610	7	
	(3)		30. Name and address of person w	no completed caus	e of death (Item 23a) (Type	P. 1. 11							-	
			POBOXY	52	TIMONIU		11	094						
		ate	31. Date filed (Month, Day, Year)	2 32. R	egistrar's Signature									
	Regist	rar	DEC 0 6 2007	fine wil	12 Book									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 4:20 DECEMBOR 2007 /Medical 4b. Chy, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 12mdollstown 1At timene If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NTSZ 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Min. Months Days 0571771924 NY 1 □ M 217 NF 074-18-0974 Director 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2000 Randallstown Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 USA 9940 Marriottsville Rd. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 같 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🎉 No Specify: Specify: White þ 3XXXdowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Aini John Mu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlington Dr. Eldersburg, MD 21784 4790 Robert Hird/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park 12/6/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 XXurial 2 □ Cremation 3 □ Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Barrier Owerfaruneral Home & Crematory, P.A. 21. Signature of Fugeral Service Lie 1212 W. Old Liberty Rd., Winfield, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) BNH od /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1∐ Yes 20 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 \_\_\_\_npatient 2 No 2 ER/Outpatient 3 DOA 1 Tes Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Augural 2 Accident 28c. Injury at Work? After t (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 10 address of person w o completed cause of death (Item 23a) (Type, Print) Old Cour steventulla 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 6 Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** James, Imbrogulio Dec 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 16, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 213-32-3212 1934 Maryland Director Usual Residence of Decedent 10d, Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 1 X Yes 2 No Baltimore n/a MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 773 S. Woodington Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 Married Specify: white 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Dock Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Fonte permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev Samuel Imbrogulio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 773 S. Woodington Road Baltimore MD 21229 Mary Imbrogulio/Wife Place of Disposition (Name of Date 20c. Location - City or Town, State Method of Disposition Cathedral Cemetery 12-8-2007 Baltimore, Maryland New 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Conation 5 ☐ Other (Specify) Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne Md 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heratocellular carcinoma
Due ti (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed ,24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of funeral 28c. Injury at Work? 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Af 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours all To the Funeral Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AU4176435M18165 December, 4, 2007 . m.D. marter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11

State Registrar 31. Date filed (Month, Day, Year)

Morton

Tiffany



Street, Battimore

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** Vivian F. Johnson 1 2007 4c. County of Death /Medical 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Cty 9. Birthplace (State or Foreign Country) Gilc<u>rest Hospice</u> If Under Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Social Security Number **Funeral** Hours Months Days 1□M 2□ 5/12/52 Director 55 217-54-4634 SC Usual Residence of Dece 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Pikesville Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 14. Race - American Indian, Black, White, etc. 906 Painted Post Rd Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housing Auth. Cl<u>erk</u> 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Andrew Bynum Lillie McGill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: if item 27 is any injury or other trainonce. 906 Painted Post Rd, Pikesville, MD 21208 Minnie Dukes/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 12/7/07 Mt Carmel Cem. Balt.,MD 22. Name and Address of Facility Hari P. Close F. Svs, P. 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Licensee PA23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DAYS **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner WEEKS CHRONIC SALRAL WOUNDS Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner sician and burial-transit MONTHS DEBILITH Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical MMOCARDIAL INFARCTION the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ O 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown CLOSTRIDIUM DIFFICILE COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an HEPATITIS certificate has b irector, page 2 s autopsy performe 1∐ Yes 2**400**0 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HDSPICE Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 🗌 Inpatient After this 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

D64395

29d. Date signed (Month, Day, Year) DECEMBER 1, 2007

30. Name and a of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES ST, STEZON BACTIMONE, MD 21204 DANIEUE O'BERMAN, MD 31. Date filed (Month, Day, Year)

State Registrar

DEC 0 6



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month November **Physician** Orris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Fulton 8. Date of Birth Oct. 9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**/** M 2□ F Marylano 219-40-1116 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene. 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No NA Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 USA Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1□Yes 2☑No 1 ☐ Never Married 2 ☐ Married Specify: Black "natural", or Specify. Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Glife. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) Building and Mental Hygin Is marked other 18. Mother's Name (First, Middle, Maiden Surname) or other traumatic event, 17. Father's Name (First, Middle, Last) Be JOMES ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 21215 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Randallstown 8-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturg Funeral Service/Licent 21229 Approximate Interval Between Onset and Death r to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Immediate cause (Final disease of condition DVONAM **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner mero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month for in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 Tillnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 No 3 ☐ DOA 1 Inpatient 2 ER/Outpatient 1 ☐ Yes Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After or Attending Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who comply

29b. Signature and title of certifier



ted cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 23a per dr., g874011606107dhbeath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month SANDRA **JACOBS** NILA ovember 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTORS COMMUNITY HOSPITAL LANHAM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 04/13/1947 219-58--2635 60 Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE OWINGS MILLS Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 CORNBURY COURT 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify Completed by Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PSYCHOLOGIST PSYCHOLOGY** 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) PEARLMAN **VEDERMAN** HARRY BELLE ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORNBURY COURT - OWINGS MILLS, MD. 21117 LIONEL JACOBS / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of DRUID RIDGE Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2007 PIKESVILLE, MD of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part . Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner espira Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis and Due to (or as a consequence of):  $\chi$ ්රීර $\omega$ Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No perform 2 X No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar FOZIA

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABE

2. Registrar's Signatur

MA

A BOULLWAN

Year)

DEC 0 6 2007

52500

8118 GOOD LICK ROAD LAWHAM MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Gertrude Jankowiak Α. ,2007 December 1:15P. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Joseph Nursing Home Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Birthplace (State or Foreign Country) 1 □ M & □ F Months Days Hours 90 213-14-2455 16,1916 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? <u>2108 Boston Street Apt 405</u> 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Anthony</u> Blusiewicz Genevieve Majewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Jankowiak (son) 7512 Riddle Ave. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-5-2007Baltimore, Maryland Holy Rosary Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Faciliticaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Hour Jelesta CordiNASAL DElose So in risky liar conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 5 ☐ Other (specify) 9 Unknown

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: if them 27 is marked other than "- any Injury or other traumout." Physician /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

or items,

Director

Funeral

þ

Completed

Be ည

death with the Maryland

burial-transit physician the as for use ed by the a signed to certificate has been si rector, page 2 should funeral director, this After t

The law requires that the death certificate be execu

Division or Vital Records, P.O. Box 68760,

Examiner History 25. Was cas eferred to medical examiner? 1 Yes 2 No 27. Manner of Death

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician/Medical by Completed Be မ Certification:

State

Registrar

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anlm, s

2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

URID

5 Pending

investigation

determined

6 ☐ Could not be

1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed 1□ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number D 34951 AUNK

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) December 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 🔲 Inpatient

(Month, Day Year)

28a. Date of Injury

Edmund Tkaczuk M.D. 405 Frederick Rd. Suite100 Catonsville, Md21228

31. Date filed (Month

32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ke 2007 11 ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist enter Daltmore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☑ M 2 □ F 2 Yrs. 218-18-7639 1924 27-Director maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 ☑ No Parkuille Funeral Director altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 2123 23a 9606 Dixon must 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ortant: If Item 27 is marked other than "natural", or Items injury or other traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married まんた。 Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify 2 Specify: white 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) sears 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H 1 and 2 should be SIE ည Jshman harles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department Pages 1 and 2.
Department of Health an Important: If Item 27 is many injury or other Baltimore Md 9606 Dixon Ave Kegina Kent-21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State moreland memorial 11/28/07 Baltimore, Marylance 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel + Cremation Svrs-Parkuille 21. Signature of Funeral Service Licensee 1 8800 Harford Read Parkville 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) week **Physician** /Medical Due to (or as a consequence of): Examiner week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine burial-trar Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes Kent, James funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To e Hospital or Attending Phys 24 hours after death. e Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 25, 2007 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Charles St. Baltwore and 21208 G-BINC 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 6 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 39029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 4,  $P^{M}$ Banks Kerfoot 2007 8:10 Larry December 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dundalk Baltimore 103 Willow Springs Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1[XM 2□ F 230-38-0356 68 November 2,1939 Virginia Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 TNo Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 103 Willow Spring Road 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Bricklayer Masonary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Graham Kerfoot Josie May Poole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

filed within 72 hours after death with the Maryland ortant: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra

**Physician** 

/Medical

Examiner

10a, State

à

Completed

Be

**Funeral** 

Director

Physician /Medical Examiner

> Fxamir burial-transi attending physician and for use as the burial-trar Physician/Medical ed by the detached Completed by has page certificate Medical Certification: To Be within 24 hours after deaur.
>
> To the Funeral Director; After this remoletely filled in by the funeral di

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

Larry J. Kerfoot	son	103 Willow	Spring Roa	ıd, Dundalk	,Maryland	21222
20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	Themoval from State   Ch	Place of Disposition (Name of cemetery, crematory or other Stanislaus Ceme		ember	Location - City or Taltimore,	
21. Ign. ture of Fineral Service Life	montelly	Conneily 7110 Sol	Funeral H Lers Point	ome Of Dune Road, Dune	dalk,P.A. dalk,MD.	21222
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the bear one cause on each line.	th. Do not enter the mode o	f dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Due to (or as a consec	th. Do not enter the mode of	ull Carci	nome of base	tanque	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consect.	quence of):				
resulting in death) Last	Due to (or as a consect	juence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □Ectopic pregr			23d. Date of deli	very Day Year
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying caus	e given in Part I.	23e. Did tobacc		the cause of death?
				24a. Was an autopsy performed	prior to c death?	topsy findings available ompletion of cause of
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3 □ DOA	Other: 4 Nursing I	Home 5 Residence	6 □Other (Spec	rify)
27. Manner of Teath  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory, of	ffice	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	nysician: To the best of my known in the basis of examination and manner stated.					
29b. Signature and title of certifier	Others	29c. Li	cense number	29d.	Date signed (Month	Day, Year)

State Registrar 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID

ETTING16

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ann. Lesser  Ann.			1 - State Registrar	State of Maryland	-	artment of Healt tificate of Dea			ienez	007	39	030
Ann Lesser  Ann Le			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	Vest	3. Time	of Death
4.6 Poly Tom or Location of Death Control Technology 1.8 Fight Meadow Lane 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Seed Security Number 1.8 Fight New Analysis of Tom 1.5 Security Number Num	Physicia:		Ann Lesser								9:30	AM M
So Source Security Numbers   Sizes   Sizes   75   Year   75   Year	Examine		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Locat	tion of Death					
Usual Residence of Decement   100. Stock and Number												
100. State   100. Control   100. Control   100. Control   100. To Code   100. Zo Code   100. Z	Funeral Director		181-30-1733	M 2071 E	* .			Mar 21,	1932	Penn	untry) Sylvan	nia nia
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	M II			10c. City,	Town or Lo	cation					10d. Inside	City Limits
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	₽ <u>₽</u>	į	MD Oueen Ans	own					1 🗆 Y	es 2√∏ No		
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	r 28s	<u>rec</u>					1	0g. Citizen o	of What Co	untry?		
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	23a o		146 Bright Meadow	Lane		21620	0			USA		
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	# E	ıner	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hispanio f Yes, specify Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)				,
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	Example 1	<u>م</u>	_	If Yes, Give								
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	lical .	eted	15. Decedent's Educ	ation completed)	16a. Dece	lent's Usual Occupation	most of work	ina	16b. Kind of	Business/	Industry	
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.		ğ	Elementary/Secondary (0-12)		life.	DO NOT use retired)		9				
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.				4				751			.on	
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	2			0.74						,		
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	natic	ို		·	105 14-70						F - 0 - 1 - 1	
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	trau		, , , , ,						•			
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	į	1		20b. Pla	ce of Dispo	sition (Name of		-				
Sequentially list conditions   FEMALE:   23d. Part   Emerth disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inches or heart failure. Ust only one cause on each line.	ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State	netery, crer	natory`or other place)	1			,	,	
25. Partl. Either the diffese, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate product of the	Suc		21. Signature Funeral Spring License Lutter 1d Sp. W	ade, Director					Balti	more	Stree	t
Immediate Cause (Final disease or condition resulting in death)  Sequentially is conditions, in Justice (or as a consequence of):  Due to (or			23a. Part 1. Enter the disease, or complice shock or heart tailure. List only on	ations that caused the death.					est,		Approxin	nate
Due to (or as a consequence of):    Sequentially list conditions, if any, listuding to simmediate gauss. Enter Underlying causs. Enter Underlying Caus	an		Immediate Cause (Final	**	= 111	VEL DOMA	<b>L</b>				Onset ar	nd Death
Sequentially ist conditions; wheeling is immunisted cause. Enter Underlying cause enter intelling in death) Last    IF FEMALE: 23b. Was deededn pregnant in the past 12 months?   1 Ures 2 Palso   9 Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   1 Ures 2 Palso   9 Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   1 Ures 2 Palso   24b. Were autopsy findings availate examiner?   1 Ures 2 Palso   1 Ures 2 Palso   24b. Were autopsy findings availate examiner?   1 Ures 2 Palso   28b. Date of figury (Month, Day Year)   28b. Describe how injury occurred   28b. Location (Street and Number or Rural Route Number, City or Town, State)   29b. Signature and title of certifier   29b. Cartifier   29c. Carti				Due to (or as a conseque	ence of):	16 60000						(60, 3
The second program of	ner											
Due to (or as a consequence of):    Contribution		ner	r any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ance of):						-	
IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1		аш	Cause (Disease or injury that initiated events c.									
FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   Month Day Year   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Live birth 2   Li		ŭ	resulting in death) Last	Due to (or as a conseque	ence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   23c. Did tobacco use contribute to the cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy profit to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy profit to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy profit to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy profit to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy profit to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy profit to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy from to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy from to completion of cause of death?   1   yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy from the completion of cause of death?   1   yes   2   No   2	- 13	lica	d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 1   Probably 4   Unknown   25. Was case referred to medical examiner?   1   Yes 2   No   No   Name and address of nerson who completed cause of death?   25. Was case referred to medical examiner?   1   Yes 2   No   No   Name and address of nerson who completed cause of death?   25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Magner of Death   Yes 2   No   No   Name and address of nerson who completed cause of the proof of the cause (s) and manner as stated.   27. Check only one)   280. Describe how injury occurred   280. Describe now injury occurred   280. Describe how injury	100	<b>O</b> 1	IF FEMALE:	to 16 year automoral of account						1		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 1   Probably 4   Unknown   25. Was case referred to medical examiner?   1   Yes 2   No   No   Name and address of nerson who completed cause of death?   25. Was case referred to medical examiner?   1   Yes 2   No   No   Name and address of nerson who completed cause of death?   25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Magner of Death   Yes 2   No   No   Name and address of nerson who completed cause of the proof of the cause (s) and manner as stated.   27. Check only one)   280. Describe how injury occurred   280. Describe now injury occurred   280. Describe how injury		an	230. was decedent pregnant	1 Live birth 2 ☐ Fetal of	léath 3□				1		,	Year
25. Was case referred to medical examiner?  26. Place of Death   Check only one    27. Magner of Death   Spending investigation    28. Diacoldent   Specify    28. Diacoldent   Specify    28. Place of Injury    29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29. Signature and title of certifier    29. Signature and title of certifier    29. Date signed (Month, Day, Year)    29. Date signe	-	ysic	1 ☐ Yes 2 Mio		am 5∟	J Other (specify)					•	
autopsy performed?    1	i			ributing to death but not result	ting in the u	nderlying cause given in F	Part I.	23e. Did tol	tobacco use contribute to the cause of death?			of death?
autopsy performed?    1		g b			1 🗆 Ye	s 2 No	3 □ Pr	obably 4	□Unknow			
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Magner of Death (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M (Specify)  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describ	3	ete						24a Was -	0 24	h Wara c	Itoney findin	ne avadabl
25. Was case referred to medical examiner?  1	- 111	Ē						autops	V	prior to (	completion of	of cause of
30 Name and address of person who completed cause of death (Item 23a) (Type Print)			25. Was seen referred to modical					The state of the s		1 🗌 Yes	2 No	
Mark Julius Mo D0041587 11/30/07	•	<b>∞</b> ∣	examiner?	ospital:	D/Own-sti-	Other						
The House who completed cause of death (Item 23a) (Type Print)	2 1	-+	the second secon			IL 3LI DOA   4L					city)	
Multiplication by D0041587 11/30/07	,	ğ	1 Natural 5 ☐ Pending									
Marie and address of person who completed cause of death (Item 23a) (Type Print)		rtifica	3 Suicide 6 Could not be	eet, factory, office	fice 28f. Location (Street and Number or Rural Route Numb			lumber,				
30. Name and address of person who completed cause of death (Item 23a) (Type Print)			(Check only 2 Medical Examin	cian: To the best of my know er: On the basis of examination	ledge, deat	n occurred at the time, da	te and place,	and due to the cared at the time, d	ause(s) and ate and plac	manner as	stated.	ea(s)
The House who completed cause of death (Item 23a) (Type Print)	ndu i	Jed	one)	and manner stated.								
30 Name and address of nerson who completed cause of death (Item 23a) (Type Print)	3	~	29b. Signature and title of certifier	1711- m-	2			7	ed. Date sig	ned (Mont	n, Day, Year	r)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  HClen A Noble 122 Speer Rd Chestertown, MD 21620  State 31. Date filed (Month, Day, Year) 32 Registrar's Signature					-	1009	120		//	100/	0/	
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature				npleted cause of death (Item 2	23a) (Type,	Print) Ld Che	s ter 1	town,	MI	) Z	1620	0
gistrar DEC 0.6.2007 Regions of Agricultural DEC 0.6.2007				32 Registrar's Signatu	те Д	wills?						

07-08788	
Patricia Lehan	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

atricia Leban		1- For State Registrar				rtment of tificate of	Death	ivienta	al Hygiene	Reg. No.	200	7 39	03
Physiciai ledical Examin	n/	Decedent's Name (First		t)					2. Date of D Month	eath Day er 12, 2007	Year	3. Time of Death	h
neulcai Examini		Patricia 1 4a. Facility Name (if not in		e street and numbe	er)		lb. City, Town, or Lo	ocation of			nty of Death		
		4402 White Oak	Avenue		,		Baltimore						
Funeral Director		5. Social Security Number			.ge (In yrs. Ia	ist birthday)	If Under 1 Year Months Days	If Under Hours	Min.	Birth(MM/DD/Y	Foreig		unk
	-	Usual Residence of Dece		M 2 X F	57	Yrs			Nov 1	2, 195	) (0	untry)	
v any	Ì	10a. State 10b. C			10c. City,	Town or Locati	on					10d. Inside City	
Maryland 28a-f show d at once.	١٥	MD				Balt						1 X Yes 2	No
e Mary or 28a	Director	10e. Street and Number 4402 White	Oak A	wenue			10f. Zip Code	10g. Citizen o		ntry?			
		11. Marital Status	unk	12. Was Deceder			s Decedent of Hispa	anic Origir		No- 14. F	Race - Ameri	can Indian, Black	k,
death or iten	Funeral	1 Never Married 2		1 Yes	s? 2 No u	ınk if Y	es, specify Cuban,		Puerto Rican, etc.)	,	White, etc.		
rs after ural", miner	<u>a</u>	3 Widowed 4  15. Decedent's Educatio		If Yes, Give Year or Dates:	mnleted)	16a Deceden	Yes 2 X No		nd of work don 1111	Spec K 116b Kind	ony.	hite	unk
5-0036 led within 72 hours a Hygiene. In other than "natura the Medical Exami	mpleted	Elementary/Secondary		College (1-4 o			ost of working life. I			Tob. rand	JI DOSITIOSS/I	industry	
5-0036 led within 7 tygiene. other than	d E	unk		ınk									
21215-0036 Uld be filed within 7 Mental Hygiene, marked other than t event, the Medica	S S S	17. Father's Name (First, I	vliddle, Last)	)			unk 18	3.Mother's	Name (First, Middle	e, Maiden Surr	ame)	un	IK
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Medium of t	10 B	19a. Informant's Name/Re	ationship (T	ype, Print )			Address (Street				Town, State	, Zip Code)	- 3
MD nd 2 sho alth and m 27 is		O.C.M.E.			Too. 5		Penn Stre				201	- 0	
Baltimore, permit. Pages I ar Pepartment of He Important: I of He injury or other tr		20a. Method of Disposition  1 Burial 2 Cre		Removal from S		rematory or oth	ition (Name of ceme ner place)	etery,	Date	20c. Loca	tion - City or	Town, State	
Itimoit. Pagartment ortant	ŀ	4 Donation 5 X O	her <i>Specify</i> .	in state	e	e2-N	amean <b>AAAA</b> ae	af⊾Facilltv∠	ard 655 1	J Ralt	imore	Street	
Ba Pern Imp Imp		Simil	10 3.	Wade Di	rector		timore,	-	21201	w. Darc	Imore	Bereet	
Physician /Medical	1	23a Part I. Enter the dise			ed the death.	Do not enter th	ne mode of dying, s	uch as car	diac or respiratory	arrest, shock, o	r heart	Approximate I Between Ons	set and
caminer	İ	Immediate Cause (Final dor condition resulting in de	isease a. eath)	Narcotic (Marcotic (Marcot	ethadone	e)Intoxic	ation					Death	
		Sequentially list condition	, h	Due to (or as a con	sequence or	j.							
	Ē	if any, leading to immedia cause. Enter Underlying	te Cause _	Due to (or as a con	sequence of	):							
sit sd	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):												
execute an and al - tran		X UNPENDED	d.		. 27 20.		IE -070 //11	1/00	. 1			1	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fumeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of t	cian/Medical	IF FEMALE:		23c. If yes, outc			Œ g878 4/11	L/U8 a	mn	23d. Da	ate of deliver	<u> </u>	-
687 certific nding p	lan/	23b. Was decedent pregna past 12 months?	nt in the	1 Live birth	at time of dea	-th	tal death 3	Ectopic	pregnancy	Mor	ith I	Day Ye	ar
Box e death the atter	75 I	1 Yes 2 No 9	Unknown		at time of dea	atn 5 Oti	ner (Specify)						
that the	by Phy	Part II. Other significant	conditions	contributing to dea	ath but not re	sulting in the u	nderlying cause giv	ven in Part				the cause of dea	
IS, P.C	g					<del> </del>			1 1 24a. W			bably 4 🗹 Unk utopsy findings av	
COrc	Completed								au	topsy		completion of cau	
ician: The certificate rector, page		25. Was case referred to r	medical T				26 Place o	of Death (	1 Ye Check only one)	s 2 No	1 🗸 Y	es 2	No
Vita ysician ysician direct	١	examiner?	Ī	lospital: 1 Inpat	tient 2	ER/Outpatient		ithor:	Nursing Home 5	Residence	6 🗸 Othe	r: Scene	
Division of Vital Records, tal or Attending Physician: The law requing a she death.  al Director: After this certificate has been side in by the finneral director, page 2 should be in the finneral director, page 2 should be in the finneral director.	١	27. Manner of Death		28a. Date of In (Month, Day	ijury ;Year)	28b. Time of I				oe how injury o	ccurred		
Sior Attend death. ector;	igi g	1 Natural 5 Pending   Fnd 11/12/07 Fnd 10:45a   1 Yes 2 X No Unk									Oit.		
Divis  Divis  pital or Al  ours after d  ceral Direc  filled in by	Certification:	3 Suicide 6 X	Could not determine	be			et, factory, office bui	liaing, etc.	or Town	n. State)		ural Route Numbe	er, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director completely filled in by the		20a Cortificat	ying Physic	ian: To the best of			red at the time, date	e and plac					
To the Ilos within 24 h To the Fur completely	Medical	2 🖳		On the basis of ex		nd/or investigat			urred at the time, da				
	≥	29b. Signature and title of	certifier	11			29c. License O.C.M		OCME		signed (Mo	onth, Day,Year)	
	-	30. Name and address of	person who	completed cause of	JM, death (Item	23a)	0.0.1			1.070111	25. 10, 2		
		Theodore M. Kin			,	•	111 Penn Stre	et, Bait	imore, MD 212	201			
Sta Registra		31. Date filed (Month, Day	(Year)		rar's Signatu	A doe	BI						

			T = For State Registrar	State of IVI	aryiand / Depa Ce	aπment of F rtificate of				7 39032
	*		1. Decedent's Name (First, Middle	e, Last)				2. Date of De	eath	3. Time of Death
	Physici /Medi		Ethel St 4a. Facility Name (If not institution	rirleu 1	Meacha	m		Month 12		Year 0: 25p M
I	Exami		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of Death		4c. County of	
		A	CHARLESTOWN NURSING HOME CATONSVILLE							TIMORE
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av Year)	Birthplace (State or Foreign Country)
	Director		212-07-0642	10 W 2 X	90 Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MARCH	13,1917	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryli sho ed al	5	,	штморг			_			1 ☐ Yes 2 ☐ Xio
	the N 28a-	ect	10e. Street and Number	TIMORE	CA	TONSVILI	JE .	1	40 - 000	
	with a or	۵		WOTER TAXE		10f. Zip Code			10g. Citizen of Wh	nat Country?
	eath is 23 must	eral	709 MAIDEN C	12. Was Decedent		2122				S.A
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marr	ied Armed Forces?  1 Yes 2 Yes If Yes, Give	No I	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖫 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity yes or No Rican, etc.)	Black,  Specify:	- American Indian, White, etc.
5-0036	hour tural	D D	3√Widowed 4 Divorced	Year or Dates:	160 P					WHITE
15	n 72 "na edlo	Completed	15. Deceden (Specify only highes	st grade completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kind of Busi	iness/Industry
2121	withi ene. than	뼕	Elementary/Secondary (0-12)	College (1-4or 5	0+) [	GENT	3)		DEAT	DCM A MD
d 2	filed withi Hygiene. Ither than		17. Father's Name (First, Middle,	<del></del>		JEN I	18 Mother's Name	e (First Middle	e, Maiden Surname	ESTATE
an	2 should be f and Mental I Is marked of aumatic eve	o Be			ERSON		ETHEL			, 
$\mathbf{Z}$	shouls ad Me mark matk	유	19a. Informant's Name/Relations			a Address (Street			GARET C	CLARK
Maryland	d2s thar thar 27 Is trau		BONNIE HANSON		- 1					
ູ້	Health Health tem 27		20a. Method of Disposition	/ DAUGITER	20b. Place of Dispo	Sition (Name of		, WOOI	DSTOCK, M	ID 21163 City or Town, State
Baltimore,	e + + 5		V⊡Burial 2 ☐ Cremation	3 Removal from State	cemetery, crei	natory or other plac	ce)			
Ħ	permit. Pa Departmen Important: any Injury once.		4 Donation 5 Dother (S		LOUDON 1			07	BALTIMO	DRE, MARYLAND
Ba	permit. F Departme Importan any Injur		21. Signature of Furieral Service	Licensee		2. Name and Addre LILLY & 1901 EAS	ZEILER	INC. I	FUNERAL BALTIMOR	HOME RE,MD, 21231
	68.00		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused						Approximate
	Physician		Immediate Cause (Final disease or condition							Interval Between Onset and Death
)	/Medical		resulting in death)		a consequence of):	ular H	cciden	<u>U</u>		
	Examiner									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
	ficate be executed by physician and streets the burial-transit	Examiner	Cause (Disease or injury that initiated events							
ó	an an	EX	resulting in death) Last	Due to (or as	a consequence of):					·
68760,	te be ysicia	edical		d						
89		edi							77.10.0	
Box	death cert e attending d for use a	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Je			23d. Date	of delivery
	0 0	Physician/N	in the past 12 menths? 1 ☐ Yes 2 ☐ No	4□Pregnant at		]Ectopic pregnancy ] Other <i>(specify)</i>			Mont	
0	that the dened by the a	hys	9 🗆 Unknown	9□Unknown						
۳,	The law requires that the te has been signed by the sage 2 should be detache	by P	Part II. Other significant condition	. 1	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
ğ	w require been sig should b		Atrial Fibr.	illation				10	Yes 2□No 3	B ☐ Probably 4 ☐ Onknown
or Vital Records,	s bee	Completed	Hypertensi	ì				24a. Was	s an 24b. W	ere autopsy findings available
æ	The fav ate has page 2:	illo	11					auto perf	opsy pri ormed? de	ior to completion of cause of ath?
ta	(0)	Ö	25. Was case referred to medical	inoma			OC Plans of David			☐Yes 2☐No
5	Physician: this certific al director,	00	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ☐ ER/Outpatien	t 3 DOA Oth	er:			
ō		<u>1</u>	27. Manner of Death	28a. Date of Inju	ry 28b. Time of	1 JUDON	4 Nursing Ho		idence 6 Other	
Division		ţ.	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		y Year) Injury		k? Yes 2 □ No			-
/isi	l or Attendatter death Director:	ţica	3 Suicide 6 Could n	ined   28e. Place of Inju	ury - At home, farm, str			28f. Location (	(Street and Number	or Rural Route Number,
ă	P ff f	Certification:	4 ☐ Homicide determi	building, etc	c. (Specify)			City or To	wn, State)	or risidi risate rumber,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledge, deatl	occurred at the tir	ne, date and place.	and due to the	cause(s) and man	ner as stated.
	ne Ho n 24 h	Medical	(Check only 2 ☐ Medical in one)	Examiner: On the basis of and manner sta	rexamination and/or in	vestigation, in my o	pinion, death occur	red at the time	, date and place, ar	nd due to the cause(s)
	To the Hospital within 24 hours a To the Funeral completely filled	M	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	(Month, Day, Year)
			Lleneer	Bowler,	ny	040	4277		12/41	07
	15		30. Name and address of person			Print)			( ( (	
_	,		Deneen Bouti	11f am, n	Maiden Car's Signature	Chrice	Lieve	Cuto	nsville.	mi) 21228
	Sta		31. Date filed (Month, Day, Year)	7. Registra	ar's Signature	.K.			1	
	Registr	ar	DEC 0 6 2	00/ Stan	AS SUPER	A STATE OF THE STA				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 01:25F CHARLES F. MCCORD, SR. ECEMBER 03. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days **X** M 2 □ F 216-20-8803 80 12/11/1926 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8311 BON AIR ROAD 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: ò Specify: WHTTE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) GOV'T. 8TH GRADE TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES MCCORD MINNIE WEITZEL ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES F. MCCORD, JR./SON 8311 BON AIR ROAD BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 12/7/2007 PARKVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK HOURS Due to (or as a consequence of): URINARY TRACT INFECTION DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2**¼** No 3 Probably 4 Unknown CHRONIC RENAL FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIABETES MELLITUS TYPE 24a. Was an 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ Certification:

be executed burial-transi Box 68760. attending physician the for use as P.O. cate has been signed by the page 2 should be detached Division or Vital Records,

certificate

this

After

e Hospital or Attending P 24 hours after death. e Funeral Director; After t etely filled in by the funera

24 hours a

To the within 2.

funeral director,

Physician:

**Funeral** 

Director

show

with

death v

be filed within 72 hours after intal Hygiene.

and Mental Hygiene.

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the <u>Medical Examiner must be notified at</u>

examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	
3 ☐ Suicide 6 ☐ Could not be determined	

29a. Certifier (Check only one)

30. Name and

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated.

DRIVE.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year,

S-306 TOWSON.

D22645 address of person who completed cause of death (Item 23a) (Type Frint)

MARYLAND

State Registrar

Medical

EREDRIC SIRKIS 7505 DSI FR 31. Date filed (Month, Day, Year)

DEC 0 6 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Mckinne-1540 M Theo 2007 11 30 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE BAYVIEW CAME CONTER BALTIMUYLE JOHN'S HOPKIN'S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Days 1□M 2XF 88 216-12-9563 APRIL 26, 1919 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Baltimore Monkton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21111 CARROLL RD 15920 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 10 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine L. Mallon Charles E. Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15920 Carroll Road Monkton, Maryland 21111 Mr. John McKinney (Son) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 12/5/2007 Rossville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirating tailure weeks Due to (or as a consequence of): Rewrent Due to (or as a consequence of): Ina mobilit Due to (or as a consequence of):

Enysician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Items 23a

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked othar than "naturel", or Ite

of Health Item 27

other

= 5

permit. Page Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

Director

Funerai

Completed by

Be

ဂ္

treumatic event, the Medical Examinar noust be notified at

Examiner the burial-transit Physician/Medical

The law requires that the death certificate be executed

Box

P.O.

Records,

Division of Vital Hospitel or Attending Physicien:

After

after death Director: /

completely

death.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 15 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ COPE 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Utf autopsy performed 2 2 No 3. CAD 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

the Funeral Director (1997) within 2 To the 0

HOW, 31. Date filed (Month, Day, Year) DEC 0 6 2007

Emil

(Check only one)

FAW ZIA

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

La Colorer

JOHNS HOPKINS BAYVIEW MED LENTER,

29c. License number

D65887

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Year

Day

3 Probably 4 □Unknown

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

11/30/2007

BALTIMORE, MD 21224

HOPILLUS BAYVIEW GROLE

Month

State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month December 3. 2007 2:20 A Joyce Ρ. Melnikoff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 👿 F 83 Nov 28, Massachusetts 1924 023-14-4152 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10311 Greentop Road 21030 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 03 Medical <u>Registered Nurse</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peterson Antoinette Wentworth Perthenia 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Melnikoff/Husband 10311 Greentop Road, Cockeysville, MD 21030 20a. Method of Disposition 20c. Location - City or Town, State Dec 6, 2007 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 21. Signature of Funeral Service Lider 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley I 10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary 23a. Part1. E er the disease, or complications shock, or heart failure. List only one cause used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate cause (Fin-I disease or condition resulting in de ill 1)11608 Coodievaschaz Atherusciento Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23d. Date of delivery 23b regnancy Month Day Year pecify) 23e. Did tobacco use contribute to the cause of death? Par cause given in Part I.

**Physician** /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-transit Physician/Medical ed by the a þ Completed Be Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic p 5 □ Other (s
-	contributing to death but not resulting in t	he underlying

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 | Yes 2 XN0 1 ☐ Yes 26. Place of Death (Check only one)

examiner?	0	Hospital	1 Inpatient	2 🗆	ER/Outpatient	3 🗆 [	OOA	Other: 4	⊠Nı
7. Manner of Death  1 Natural 2 Accident	5 ☐ Pending investigation		Date of Injury (Month, Day Ye	ear)	28b. Time of Injury	M	28c.	Injury at Work? 1 ☐ Yes	2 🗆
3 ☐ Suicide	6 ☐ Could not be determined	28e.	Place of injury	At h	ome, farm, stree	et, facto	ory, of	fice	

irsing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred No

28f. Location (Street and Number or Rural Route Number, City or Town, State) building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signature	and title	of se	rtifier
		( ,	)	4

25. Was case referred to medical

4 ☐ Homicide

29a Certifier

29c. License number

29d. Date signed (Month. Dav. Year)

December 4, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tariq Mahmood, MD 19 Ridge Road, Westminster, MD 21157

31. Date filed (Month, Day, Year) State Registrar

10

Medical

DEC 0 6 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Deramse 0110 200 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A MAI If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, Security Number 7. Age (In yrs. last birthday) 6, 1948 **Funeral** Days Hours 1 □ M 2**X** F 59 Maryland 214-78-4437 June Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** Brooklyn Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21225 118 1/2 Camrose Street 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify Be Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barmaid Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peggy Miller Jim Griffin ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1714 Belt Street Baltimore, Maryland 21230 Robin R. Resinger, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 12/05/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Si natur Funeral Statice La risee Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** たらたか nk. www /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and \square strans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 I Inknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 nknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 5 performed 2 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 1 🗌 Yes 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SUSIE100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herover Street Beltwore W1602000 31. Date filed (Month, Day, Year) DEC 0 6 Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

			_ FOr	Maryland		rtment of H		lental Hyg	iene		
			State Registrar		Cer	tificate of L	Death	2. Date of Dea	eg. No. 2	007	39038
	Physicia	an	Decedent's Name (First, Middle, Last)  Thoughtours  Edv	mund	Disco	.+		Month	Day	Year 2007	10:55 P <sup>M</sup>
ĭ	/Medic Examin		Thaddeus Edr  4a. Facility Name (If not institution, give street and numb	mund ber)	Pro		Location of Death	Decemb	4c. County of Death		
;	LXdillill	CI	Copper Ridge				sville		Carroll		
	Funeral		1 □ <b>V</b> M 2 □ E	. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Co	hplace (State or Foreign untry)
Ė,	Director		213-22-1806 Usual Residence of Decedent	83	110.			Dec. 8	, 1923	IMIS	ryland
	ryland how		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	ne Mau 8a-f s	Director	Maryland N/A	В	altimo						1 ☐XYes 2 ☐ No
	with the	Dire	10e. Street and Number			10f. Zip Code 212	10		l0g. Citizer	of What Co U.S.A	
	ns 23 must	Funeral	3808 Fenchurch Road  11. Mantal Status 12. Was Deceded	ent Ever in U.S	. 13. V	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	14.	Race - Ame	rican Indian,
٥	after o		Armed Forc	es? 1942-19! es.	52	f Yes, specify Cuba 1 □ Yes 2[X] No	n, Mexican, Puerto Specify:	Rican, etc.)	Sr	Black, White	e, etc.
2-003p	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by		₽s. <b>¬~ 1</b> J.		lent's Usual Occupa				Wh of Business/	ite
<u>.</u>	in 72 n "nat Aedica	plete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4	1or Eu	(Give	kind of work done of NOT use retired	luring most of work	ing	TOD. Kind	or business,	industry .
212	d with giene er thau	Completed	Elementary/Secondary (0-12) Conlege (1-4	+01 5+)	Med	dical Doc	tor		Med	dicine	
land	be filed within 72 hours after death with the Marylan at Hygiene. ed other than "natural", or ftems 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name				
>	hould be d Menta marked matic ev	우	Carrow Tolso  19a. Informant's Name/Relationship (Type. Print)	on	Prout 19h Mailin	ig Address (Street a		Mary al Boute Numbe		rrick	Zin Code)
Ma	nd 2 s ulth an 27 is r r traun		Eleanor Prout Wife			Fenchurc		altimore	-		
e,	es 1 al of Hea item		20a. Method of Disposition	1 00	ice of Dispo	sition (Name of natory or other place	i	Date		ion - City or	
altımore,	Page ment c ant: If ury or		1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from St	Hil	1top S	Service Co			Tow		Maryland
gall	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone.		21. Si matter of Lineral Servici Licensee			2. Name and Addres		ck Towse			Home, Inc. 21204
Ü			23a. Part1. Enter the disease, or complications that cat shock, or heart failure. List only one cause on eac	used the death. ch line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or contition a.			Demen	tia			1	Onset and Death
'	/Medical Examiner		resulting in death)  Due to (or	r as a conseque	ence of):						,
		ier	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r as a conseque	ence of):						
1	cuted nd ransit	Examiner	that initiated events							- 20	
ρÇ,	cate be executed physician and the burial-transit	EX	resulting in death) Last Due to (o	r as a conseque	ence of):						
28/60	icate physics the b	dical	d								
nox	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes			7e . ·			230	I. Date of de	livery
ŭ ŭ	e death	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregna	th 2 ☐ Fetal on Int at time of dea		Ectopic pregnancy Other (specify)				Month	Day Year
٦ ک	at the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to dea		ting in the w	ndarlying cause give	an in Part I	23e Did to	hacco use	contribute to	the cause of death?
ďŠ,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bural-transit	d by	Tartin Giner significant contains contains and	att bat not room	ang in alo a	naonying oaddo givi	or are a	1 🗆 Y		,	robably 4 Unknown
Hecords	> 0.0	Completed						24a. Was a		24b. Were a	utopsy findings available
	iclan: The lav certificate has ector, page 2:	omb							sy med2 2 No	prior to death? 1 □ Yes	completion of cause of 2 □ No
VITal	clan: ertifica ector, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
<u>_</u>	Physic this c	유	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ In 27. Manner of Death 28a. Date of		R/Outpatier 28b. Time of		4 Nursing H	ome 5 Resid			ecify)
0	th. : After	tion	1 ☑ Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	, Day Year)	Injury	Worl	k? Yes 2 □ No	200. Describe in	low injury d	ccurred	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. Place of	of injury - At hong, etc. (Specify)		eet, factory, office		28f. Location (S City or Tow	Street and f n, State)	Number or R	ural Route Number,
_	spital		29a. Certifier 1 Certifying Physician: To the b								
	the Ho hin 24 P the Fu npletely	Medical	(Check only one) 2 Medical Examiner: On the base and manner		on and/or in						
1	vii To	-	29b. Signature and title of certifier	great	0	29c. Licens	005994				th, Day, Year)
/	25+1		30. Name and address of person who completed cause	· ·	23a) (Type,		2 357	We Stra	hele	/ M-	2 2157
	Sta			gistrar's Signati	ure	100	- 7~1	VV ) Jest		<i>y j</i> · <i>y</i>	-43/
	Registr	ar	220 9 0 2007	we so	A STATE	3428					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** William Price December 3, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Union Memorial Hospital Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 5, 1935 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 219-30-5334 10M 2□ F Country 72 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 4140 The Alameda 21218 U.S.A.

14. Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Steel Worker Bethlehem Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Price Mae Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pattie Price/Wife 4140 The Alameda Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GarrisonForestVetCemDecl2,2007OwingsMills,MD 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTIMORE, 21. Signature of Funeral Serve Licensee MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary 40 years /Medical Due to (or as a consequence of): Examiner Hypertension 40 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine End stage Renal Disease burial-transit Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed After this certificate has been funeral director, page 2 shouls 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2□No Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.0. Division or Vital Records,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arleen K. Lamba, M.D. Union Memorial Hospital, MD 31. Date filed (Month, Day, Year) DEC 0 6

29b. Signature and title of certifier

32 Registrar's Signature

Lamba M.D.

29c. License number

29d. Date signed (Month, Day, Year)

A72438946 December 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Rita Helen Rice 3. 37AM DEC 01 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL n/a ST. AGNES Baltimore | Months | Days | Hours | Min. | Min. | Min. | March | 9, 1924 | Maryland | M 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🖾 F 83 220-12-2931 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 202 South Augusta Ave United States 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American I Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: δ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Francis Sadler Molly May Schalisky 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah M. Rice / daughter 202 South Augusta Ave Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 4 □ Domation 5 □ Other (Specify) 12/5/2007 Baltimore, Maryland 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signal re of Funeral S rvice License 1328 Sulphur Spring Rd Halethorpe, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ANEURYSM RUPTURE Immediate Cause (Final AORTIC 1 weck disease or condition resulting in death) Due to (or as a consequence of): GASTROINTESTINAL BLEED UPPEN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Abdominal Aortic Angurysm that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ဥ 1 Tyes 1 Minpatient Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death accurate the cause of 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f shov event, the Medical Exa<u>miner must be notified at</u>

death v

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene. is marked other than

traumatic

Department of Health au important: If Item 27 is any Injury or other trau

**Physician** 

/Medical

Examiner

ed by the attending physician detached for use as the buria

has

filled in by the funeral

completely

Baltimore, Maryland 21215-0036

Division or Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar MD

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

P- 19508

DEC, 1, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AIRI AIS MASOOD 900 S CATONS AVE BALTIMORES MD

DEC 0 6 2007



State Registrar 31. Date filed (Month)

10

eHill CT. Lutherville, Md 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ovenber 27, 2007 Lawrence Rainey /Medical 4a. Facility Name (If not institution, give street and number) 4h City, Town, or Location of Death 4c. County of Death Examiner Genera saltimore If Under 1 Year | If Under 24 Hrs. . Social Security Number 6 Sex Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk **Funeral** Days Hours 1 ₹ M 2 □ F unk 43 215-96-2618 Director Apr 2, 1964 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1√Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 501 W. Franklin Street USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married unk 21215-0036 1 ☐ Yes 2 No Specify Specify. black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland General Hospital 827 Linden Avenue Baltimore. MDBaltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify) in state . Signature of Euneral Service Ronal d S. Wade State Anatomy Board 655 W. Baltimore Street un Baltimore, MD 21201 23a. Part1. Inter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Ir heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncritying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the detached 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ ₩6 24a. Was an page 2 autopsy performed? /es 2 \(\textstyle{1}\) No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 3□ D0A 1 Yes 2 No 2 R/Outpatient 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ie Hospita or Attend 24 hours ter death ie Funeral Director death. 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

completely within 24

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

agistrar's Signati

D47405 11/28/07 Enst. Baltime MD21201

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Elementary/Secondary (0-12)

12TH

Josie Bowersox

21. Signature of Funeral Service Licensee

20a. Method of Disposition

disease or condition resulting in death)

Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

17. Father's Name (First, Middle, Last)

Completed

Be

	12	-	2	- 2007
City, Town, or Location of Death			4c. C	ounty of Death
Towson			В	altimo

altimore Co.

Specify: White

11:47 a

9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 9-27-1917

10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country?

Reg. No.

10f. Zip Code

21224 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.

2. Date of Death

16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

<u>Machine Operator</u> Crown, Cork & Seal 18. Mother's Name (First, Middle, Maiden Surname)

Peter W. Raczniak Anna Kieltyka 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8083 Park Haven Rd. Dundalk, MD 21222

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date

Stanislaus Cem. 12-7-07 Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA

1201 Dundalk Avenue Baltimore, MD 21222

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

3 Ectopic pregnancy

5 Other (specify)

Certificate of Death

Months

1 ☐ Yes 2 No

If Under 1 Year | If Under 24 Hrs.

Hours

Specify.

Days

Approximate Interval Between Onset and Death DAYS Due to (or as a consequence of):

SACRAL CHRONIC WOUNDS

Directs for as a nonsequence of

DEBILITY

Raczniak

College (1-4or 5+)

7. Age (In yrs. last birthday)

90

10c. City. Town or Location

<u>Baltimore</u>

Due to (or as a consequence of):

MONTHS

YEARS

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nnknown

4□Pregnant at time of death

24a. Was an

autopsy performed? /es 2 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

OFFERBER 2, 2017

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dther (Specify) Hospital: 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 NCHARLES ST. SUITE 209 BALTIMORE, MO 21204 DANIONE DIBERMAN, MO

D64395

31. Date filed (Month, Day, Year)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Jivision or Vital Records, P.O. Box 68760

attending physician for use as the buria Hospital or Attending Physician:

signed t certificate has been si rector, page 2 should funeral director,

**Physician** 

/Medical

Examiner

gg/

Examine

Physician/Medical

þ

Completed

Be

Certification: To

IF FEMALE

24 hours within 2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:42 a M MARGARET ANN SOUERS DECEMBER 2,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMUKE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Aug. | 16,1931 121 S. DURHAM STREET N/A9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□м 2ХТР 218-28-5123 76 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1XYes 2 No BALTIMORE Director N/A10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 121 S. DURHAM STREET 21231 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2X No Specify. 9 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 LABORER MANUFACTURING and Mental Hygier is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event once. Be RETHY DAVIS **JEANETTE** LEDDON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANA WLOCZEWSKI/ GRANDCHILD 121 S. DURHAM STREET, BALTIMORE, MD 21231 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐Removal from State OAK LAWN CEMETERY 12/5/07 4 Donation 5 Dother (Specify) BALTIMORE, MARYLAND 22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD. 21. Signature of Funeral Service Licensee 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE PULLORY **Physician** ENDSTAGE disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and stransit sthe burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 ☐ Other (specify) been signed by the a should be detached t 9 ☐ Unknown Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Manper of Death 1 Matural 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anniauxous MD D16619 DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BALTIMORE NO 21236 9940 FRANKUN SQUARE C.VERGARA - SOARES 31. Date filed (Month, Day, Year) 327 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

DEC 0 6

BERRI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN TITM/29d, per PHYS. C874.12/6/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 11 **Physician** 12007 enger Audreu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Poin Co. are 100attimore FLETRETE If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Min Days Hours Months 1 □ M 2 🙀 F 212-34-7611 79 Director Jan. 12,1928 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director Baltimore Maryland Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō United States Items 23a 1604 Browns Road 21221 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify 3√2 Widowed 4 □ Divorced White 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home Ith and Mental Hygings 27 le marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Schy Brodsky Gertrude May Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health a: If item 27 le Cheryl White (Daughter) 8541 Water Oak Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page
Department of
Important: If
any injury or
once. Øak Lawn Cemetery 12/1/2007 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Duda-Ruck Funeral Home of Dundalk, Inc. Enter the disease, or complications that caused the deat. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physicien and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending to use as IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending Vithin 24 hours after death.

To the Funeral Director: After the funeral by the f 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 29a. Certifier Contifying Physiciam: To the best of my knowledge, death secured at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Date signed (Month, Day, Year) 29b. Signature and title of certifier November, 28, 2007

Registrar

State

30. Na

31. Date fi

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Nood

			For State Registrar	State of Marylan		artment of H tificate of I			Reg. No UU/	39046
	Physici	an	Decedent's Name (First, Middle, Las					2. Date of De Month	Day Year	3. Time of Death
	/Medic	cal	Evelyn Schulth			4h Cihi Taura ai	r Location of Deatl	Novemb	er 30 2007 4c. County of Dea	9:15
	Examin	er	4a. Facility Name (If not institution, give	yview Medical G	enter	Baltima		1	N/A	
	Funeral	7	Social Security Number 6. S	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th 9. Bit	rthplace (State or Foreign ountry)
	Director		215-03-8436	□M 2 <b>X</b> 0F 90	Yrs.	Months Days	Hours Min.			aryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. fnside City Limits
	Maryl	ō	M1				Dunda	7.1-		1 ☐ Yes 2 No
	r 28a	Director	Maryland Balti 10e. Street and Number	more		10f. Zip Code	Dunda	1K	10g. Citizen of What C	ountry?
	23a o		233 Ashwood Roa	d		2122	2		United St	ates
	r dee	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puen	pecify Yes or No to Rican, etc.)	14. Race - Am Black, Whi	
20	hours after deeth with the Maryland tural; or Itama 23a or 28a-1 ahow at Esartinal must be notilled at	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
		ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	
215-0036	within 72 ene. than "na	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done on DO NOT use retired	during most of wo	rking		
7	filed wii Hygien other th	Con	8 Years		H	memaker			Own Hom	e
⊑	o d a b ≥	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
Ž	should nd Men marka umatic	ဥ	John Smyth  19a. Informant's Name/Relationship (1)	Vpe. Print) Husband	19b. Mailir	ng Address (Street	Lula and Number or Ru		er, City or Town, State.	Zip Code)
<u>8</u>			Mr. Walter D. Sch			-			Maryland 21	
J.			20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location - City o	r Town, State
Ĕ	mit. Pages ' partment of H portant: If its y injury or ot		1 E Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		Cemeter		/2007	Baltimore	, Maryland
Baltimore,	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licen	509		2. Name and Addre		Home o	f Dundalk,	Inc.
_	₹0'E € 0		Jeuler a. J	oner		922 Wise	Ave. D	undalk.	Maryland 2	
			23a Part 1. Enter the disease, or born, shock, or heart failure. List only Immediate Cause (Finat				ig, such as cardia	c or respiratory a	111951,	Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Respiration  Due to for as a consequence	1 tail	ule				1 hour
	Examiner			b. Pheymonic						5 days
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq						
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	wanaa af);					
/60,	be ex icien burial	calE	4	Due to (or as a conseq	delice or).					
/89	flicate g phys			d						
ROX	death certiticate be executed e ettending physicien and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Feta		Ectopic pregnancy	ı		23d. Date of d	•
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d		Other (specify)			Month	Day Year
л О	law requires that the de es been signed by the e 2 should be detached i		9 Unknown  Part II. Other significant conditions c		ulting in the u	ndarhina cause an	en in Part I	23e Did	tobacco use contribute	to the cause of death?
Š,	ilres thet signed b	1 by	Partin, Other significant conditions of	orthodaling to death but not les	aking in the a	indenying cadse giv	ent at rasts.			Probably 4 Junknown
Ö	w requir been si should	ete						24a. Wa	an 24h Were	autopsy findings available
Division of Vital Records,	The lar	Completed	<del></del>					auto	ormed? death?	
Į		0	25. Was case referred to medical				26. Place of De	ath (Check only	2.☑No t ☐ Ye	35 ZLI NO
₹	<u>&gt;</u> .₩ 0	To B	examiner?	Hospital: 1- Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	105		idence 6 Other (Sp	ecify)
0	ding Ph h. Atter th funeral		27. Manner of Death  1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occurred	
<u>s</u>	Attending ir death. ector: Atter by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	1	ama farm at		Yes 2 □No	28f Location	(Street and Number or I	Pural Route Number
<u>&gt;</u>	2 2 2 2	ertif	4 Homicide determined	building, etc. (Specif	fy)	eet, factory, office			wn, State)	turzi route rumber.
	pita ours tille		29a. Certifier 12 Certifying Ph	ysician: To the best of my kno	owiedge, deat	h occurred at the tir	me, date and plac	e, and due to the	cause(s) and manner	as stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	opinion, death occ	urred at the time	, date and place, and do	ue to the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor	
)			12			RES-C	700		November :	30,2001
Ĺ	0		30. Name and address of person who	D 11011	n 23a) (Туре,	Print)	ue Buttin	rure Mi	217.24	
Y	Sta	ato	31. Date filed (Month, Day, Year)	32. Registrar's Signa		CTVI TOOP	Company 11877	- 1 1	-10-1	
	Regist		DEC 0 6 20	AG.		and a				
DHN	/IH 17 Rev 1/2	001	UEG 0 0 20	UI James Je	To the	64-				
					ORIG	NAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month rances sutherland 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NI university of Mary and Baltimore Hedical Jener If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | AUG 28 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 50 DC Director 578-84-2499 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 □Yes 2 No Director Anne Arundel Laure1 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 20724 196 Charlotte Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TXYes 2 □ No
If Yes, Give
Year or Dates: 78–81 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 9 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Private School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Sutherland ပ Betty Ortman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Currie - husband 196 Charlotte Road, Laurel, MD 20724 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 12/4/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bowel Ischemia /Medical Due to (or as a consequence of): Examiner im hosis Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed burlaf-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the ası IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 Who
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was a... autopsy performed? Ves 20 No 1∐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only on examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 npatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. 30 21141

State Registrar 31. Date filed (Mooth, Day, Year)

7

DHMH 17 Rev 1/2001

ORIGINAL

12

32. Registrar's Signature

Baltimore

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

urards

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month November 16 2007 728 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) University of Maryland Medical System timore 5. Social Security Number If Under 1 If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1⊠M 2□F Months 213-82-2030 Maryland May 5, 1961 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No MD Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 2611 Woodland Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 laborer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Phillip Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Trent/daughter 2828 Montebello Terrace Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 M Other (Specify) in state Wade, Director 21. Signature o Funeral Service Licensee Ron S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) loblastoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2000 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident

**Physician** /Medical Examiner

certificate be executed

Box 68760,

Records, P.O.

or Vital

Division

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral in the fun

**Physician** 

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or items 23a

n and Mental Hygie

permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 Is
any Injury or other trau

the Medical

within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Director

Funeral

ò

Completed

Be

attending physician and for use as the burial-tran signed by the a d be detached f page 2 s this

Examiner

Physician/Medical

Completed by

Be

P

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 🗀 Yes

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

6 ☐ Could not be

29d. Date signed (Month, Day, Year) November 16, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

completed cause of deam (Item 23a) (Type, Print) 30. Name and andress of person with

South Greene Street Baltimore, MD 21201 verve

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 1,2007 9:40 A.M Sadie Bessie Sohn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore GenesisElderCare-Heritage Ctr. Dundalk | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept7, 1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 □ M 2 📉 I 94 Maryland 214-01-3235 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21231 U.S.A. 2108 Boston Street Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 7th Home Maker

**Physician** /Medical Examiner

e attending physician and

signed by the a d be detached f

certificate has birector, page 2 s

this funeral

. After

after death.

Director: /

within 24 hours a

To the Funeral C

completely filled

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Department of Health and Mental Hygis Important: If Item 27 Is marked other any injury or other traumatic event, <u>il</u> once.

Physician

/Medical

Examiner

10a. State

Md.

**Funeral** 

Director

a or 28a-f show be notified at

ral", or items 23a Examiner must b

"natural", or

Director

by Funeral

Completed

Be

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

immediate Cause (Final disease or condition resulting in death)

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Robert

23a. Part1. Enter the disease, or co shock, or heart failure. List or

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

	,
mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres ly one cause on each line. a. CEREBROUAS CULCAR ACUDE M	Interval Between
b. A TRIAL FIBRILLATION  Due to (or as a consequence of):	
c. Hypotho (or as a consequence of):	
L. DEMENTIA	
23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year

Completed by Physician/Medical Examiner Be

Certification: To

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

(unk)

1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death

5 Other (specify)

Linda Ruffner/Granddaughter14 Talister Court Baltimore, Md 21237 20b. Place of Disposition (Name of cemetery, crematory or other place)

23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Donknown

20c. Location - City or Town, State

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform 1□ Yes 2 **D** No

26. Place of Death (Check only one,

18. Mother's Name (First, Middle, Maiden Surname)

Christina Kellner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Bayview Crematory12-3-2007 | Baltimore, Maryland

22. Name and Address of FacilitKaczorowski Funeral Home, PA

1201 Dundalk Ave. Baltimore, Md. 21222

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Mo 27. Manner of Death 1 Naturel 5 Pending investigation

2 Accident

3 Suicide

4 ☐ Homicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 6 ☐ Could not be

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred

28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifie

determined

29d. Date signed (Month, Day, Year)

Hospital:

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			_ State	State of Maryland		ment of He				00051
			Registrar  1. Decedent's Name (First, Middle, Last)		Ochin	cate of L		2. Date of Death	g. No. 2007	3 Time of Death
	Physicia	an						Month	Day Year	12 95 PM
	/Medic		Mae Tarbart  1a. Facility Name (If not institution, give si	reet and number)	4h	City, Town, or	Location of Death	November	4c. County of Death	
	Examin	er	FRANKLIN SOUCYE	HOSPITAL CE		Rose	Λ .		Baltin	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I			If Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign untry) unk
	Director		216-14-8870	M 2₹ F 85	Yrs.	onths Days	Hours Min.	Jan 30,		unk unk
			Usual Residence of Decedent					Jun 30,	1722	
	nylan how		10a. State 10b. County		r, Town or Locatio	on				10d. Inside City Limits
	e Ma 3a-f s	cto	MD Baltimore	2	Middle R	iver				1 □Yes 2 No
	or 28	Dire	10e. Street and Number	) J	1	Of. Zip Code	0.00	10	g. Citizen of What Cou	untry?
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	219 Riverthorne I				220		USA	
	tems	nue	11. Mantai Status	2. Was Decedent Ever in U.: Armed Forces?	S. 13. Was	Decedent of His s, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	Z Z	1 ☐ Never Married 2 ☐ Mamed 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 🗆 '	Yes 2∑No	Specify:		Specify: W	hite
9	hour tural	Completed by	15. Decedent's Educ		16a. Decedent	s Usual Occupa	ation	unk 1	6b. Kind of Business/I	ndustry
. 15	in 72 "na fedic	olet	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind		urina most of work	ing ulik		ndustry un
7 2	with jene r than	E	unk ur	College (1-4or 5+)						
nd	othe rent,	Bec	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	e (First, Middle, M	laiden Surname)	unk
<u>'ar</u>	Aenta Aenta rked tic ev	To								
Maryland 21215-0036	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Typ		1				City or Town, State, Z	
- ≥	and 2 ealth n 27 i		Franklin Square Ho		<u> </u>		Square I	rive Ros	edale, MD	21237
Baltimore,	- T 5 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		lace of Disposition emetery, cremato	n (Name of ory or other place	e) :	Date 2	0c. Location - City or	Town, State
	Pages ment of P ant: If ite ury or o		4 □ Donation 5 ☑ Other (Specify)	in state						
a t	permit. Departmine importa any inju		21. Signature of Euroral Service License Ronald S. W	ade Director	22. Na	me and Addres	s of Facility	1 655 W	Baltimore	Street
	89 2 2 2		1. Jan 1/1/1	MI	- Balı	timore,	MD 2120	1 055	Dareimore	bereet
			23a. Part1. Enter the disease or complic shock, or heart failure. List only on	ations that caused the death cause on each line.	n. Do not enter th	e mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician	7.1	Immediat Cause (Final disease or condition	Infector	wal	1 Myc	scardi	aL IN	Faretion	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ						
6	Examiner		Sequentially list conditions. b.	Coronar		Tery	DISEC	5 4		
	Po ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):	4				
	and trans	cam	that initiated events resulting in death) Last	Due to (or as a consequ						
8760,	cate be executed oblysician and the burial-transit	E E	and the second s	Due to (or as a consequ	ience or):					
87	ate to	dica	d.							
9 ×	Physician: The law requires that the death certificate has been signed by the attending praidirector, page 2 should be detached for use as	Physician/Medical	IF FEMALE:	o If you outcome of pregna	DOV					
Вох	attend for us	ian,	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome pf pregna	I death 3 ☐ Ect	opic pregnancy			23d. Date of deli Month	very Day Year
	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5∐Utr	her (specify)				
P.0	w requires that the d been signed by the should be detached		Part II. Other significant conditions con	ributing to death but not resu	ulting in the under	lying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	signe d be	d by			•			1 □ Ye	s 2 No 3 Pro	obably 4 Hinknown
Ö	requiper shoul	Completed						04-144	1045	F - C
36	has ge 2 :	ld m						24a. Was an autopsy perform	/ prior to d	topsy findings available completion of cause of
<u>=</u>	icate							1□ Yes 2	☑No 1 ☐ Yes	2 1 No
ΖÏ	stcian: The is certificate ha irector, page 2	Be	25. Was case referred to medical examiner?	ospital:		Othe	ir.	h <i>(Check only one</i>		
ō	Phys	7.	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatient 2 2 28a. Date of Injury	ER/Outpatient 3 28b. Time of	DOX	4 🗆 Nursing Ho	ome 5 Resider	nce 6 Other (Spec	cify)
n	ding J. After funer	io	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work	? Yes 2 □ No	200. Describe no	w injury occurred	
Si	death ctor: y the	ical	3 Suicide 6 Could not be	28e. Place of injury - At ho			.00 2	28f Location (Str.	eet and Number or Ru	ıral Route Number
Division or Vital Records,	or A after Dire	Certification:	4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	()	,,		City or Town,	State)	,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a, Certifier 1 Certifying Phys	iclan: To the best of my kno	wledge, death oc	curred at the tim	ne, date and place	and due to the ca	use(s) and manner as	stated.
	24 h e Fui etely	Medical	(Check only 2 Medical Examination)	er: On the basis of examina and manner stated.	tion and/or invest	igation, in my of	pinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)
	Nithin Vithin Го th	Me	29b. Signature and title of certifier			29c. License	number	29	ld. Date signed (Monti	h, Day, Year)
	- > - 0		) (huk	1 22 2	MD	DXX	56195	7	11/20	2007
			30. Name and address of person who con	npleted cause of death (Item	23a) (Type, Prin		00.10	•	,	<u> </u>
					FRANKL	•	DRIVE	Baltin	more M.	0 21237
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture /			120011	-101 - 771	
	Registr		DEC 0 6 2007	Aller Jan 18	porce	1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 25,27 per me, g874-12/20/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Z8 **Physician** ERIL LAIRS TANT 215 07 11 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE VA MEDICAL LENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number unk 6. Sex Birthplace (State or Foreign Country) **Funeral** Days **Director** Jan 4, 1948 Canada Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show effical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Director Dunda1k 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1911 Haselmere Road 21222 Canada Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 self employed janitorial Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, tt once... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Alice Smith/caregiver 1911 Haselmere Road Dundalk, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state Director 21. Signature of Funeral Service licensee Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAIN NOXIC Physician /Medical Due to (or as a consequence of): Examiner RATION SETTING AT TON ASSESSED BY MEDICAL EXAMILES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1x Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

MOSKOUN OSHOA 31. Date filed (Month, Day, Year)

DEC 0 6 2007

29b. Signature and fitle of certifie

30. None and address of person



MU

MID

who completed cause of death (Item, 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

18269

10 D GREEN

altimore, Maryland 21215-0036 P.O. Box 68760. Division or Vital Records, within 24 hours after death To the Funeral Director: Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Baltimore, MD 2122 arer 31. Date filed (Month, Day, Year)
DEC 0 State 0 6 2007 Registrar

			For State Registrar	State of I	Marylan	•	artment rtificate			and M	ental Hy	giene Reg. No.	007	39054
	Physici /Medi	cal	1. Decedent's Name (First, Mid  MYLIAH;  4a. Facility Name (If not institut	PAITH AND		Mce	RIDE,				2. Date of De Month  DEC	Day 04	Year 200 County of Deat	
	Examir Funeral Director	ner	CNIVERSITY OF . 5. Social Security Number N/A	MARYLAND MO	EDICAL	LÉIVTRE last birthday) Yrs.	BP If Under 1	LTII	MORE If Under: Hours	9	8. Date of Bir (Month, Da	th ay, Year)	ALTIM	
	Maryland I-f ehow	tor	Usual Residence of Decedent           10a. State         10b. Coun           MD         N	rty /A		y, Town or Lo			· · · · · · · · · · · · · · · · · · ·		·			10d. Inside City Limits  X☐ Yes 2☐ No
	ath with the 23s or 28s	ral Director	10e. Street and Number 2814 Walbroo					216			1		en of What Co USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other then "natural", or itams 23a or 28a-f ehow important: If item 27 ie marked other then "natural", or itams 25a or 28a-f ehow hy injury or other traumatic event, the Madical Examinar must be notified at Angle.	leted by Funeral		If Yes Give	s? XNo	16a. Dece	Was Decede f Yes, specification 1 Yes 2 dent's Usual kind of work DO NOT use	No Occupat	Specify:		cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: <b>Fri</b> Ameri d of Business	e, etc. .can .can
	filed within Hygiene. other then	e Completed	Elementary/Secondary (0-12  0  17. Father's Name (First, Middle		or 5+)	N/Z			18. Mothe	or's Name	(First, Middle	l	N/A Gumame)	
Maryland	2 should be filed withir and Mental Hygiene. ie marked other then aumatic event, the M	To B	Curtis Mc		· · · · · · · · · · · · · · · · · · ·	19b. Mailir	ng Address (				Willia Route Numb		Town, State, 2	Zip Code)
Baltimore, M	Pages 1 and 2 nent of Health a int: If item 27 is iry or other trai		Keyona Will  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other	n 3 🗆 Removal from Sta	20b. P	2814 Place of Disponentery, cremetery, cremetery	sition (Name matory or oth	e of ner place	) 1	-	3alt., ate /07	20c. Loc	21216 ation - City or	
Balt	permit. Pag Department importent: I eny injury o		21. Signature of Funeral Service	6	د		5126	Bela	air	Rd,	Balt.	, MD	F. Sv 21206	rs,PA -5105
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	- a PULM		Y MYF				cardiac o	r respiratory a	irrest,		Approximate Interval Between Onset and Death © DA V.S
8760,	sate be executed shysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SEVER Due to (or  c. CHROM Due to (or		AL AN								7 DAYS
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and tail director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 MarNo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta t at time of d	I death 3	Ectopic pre					2	3d. Date of dea	ivery Day Year
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant condi	itions contributing to deat	h but not res	ulting in the u	nderlying cau	use giver	n in Part I.			tobacco us Yes 2 ⋤	/	o the cause of death? robably 4 □Unknown
al Records,	icien: The law re certificate hes be rector, page 2 sho	Completed									1 Yes	psy ormed? 2 No	24b. Were at prior to death? 1 ☐ Yes	utopsy findings available completion of cause of
Vital	ysicien: iis certific director,	To Be	25. Was case referred to medic examiner?  1 Yes 2 No	Hospital: 1 Nnp.	atient 2	ER/Outpatier	it 3 DOA	Other	-		Check only		☐Other (Spe	cifv)
Division of	ding After	Certification: 1	4 57 100 100 11	stigation	njury Day Year)	28b. Time of Injury	M 28	c. Injury Work? 1 🗆 Y		No	8d. Describe			,,
Divi	oital or Attendurs after death		4 Homicide dete	mined 256. Place of building,	etc. (Specif	y) 		,			City or To	wn, State)		ural Route Number,
	To the Hospital or Attent within 24 hours after deatt To the Funaral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1	ring Physician: To the basis al Examiner: On the basis and manner	s of examina	widdys, deal tion and/or in	vestigation, i	t the time in my opi License	nion, dea	th occurre	and due to the	date and	place, and due	to the cause(s)
	F 18 6		30. Name and address of person	i MO	of death (Item	n 23a) (Tuno	l (		346	51		DE		04 2007
Y 2000	1		KONDURU KA	VITHA, MD.	225	GIREEI	VE ST	т, В	BALTI	MOR	E, MD	213	201	
	Sta Registi		31. Date filed (Month, Day, Yea	32. <b>P</b> (s)	strar's Signa	iture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 28a, b, c, e, per dr. 28/4, 12/06/0/dhb

Reg. No.

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day WHITFIELD, SR **Physician** WILLIAM 0176 m 11 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University City Moryland Bultimore of 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/13/1931 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218769064 Days 1 M 2□ F Months Hours 76 Yrs. MD Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits works is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1¥Yes 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Madison 21217 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∭Wes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Editor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Belle Nina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
249 Madison Avenue Balto NID 21217 19a. Informant's Name/Relationship (Type. Print) Daughter Whitheld 2419 Madison Michelle permit. Pages 1 a
Department of Hea
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Mills, MD 21/07 Gamison Forest C. Greene Funeral EVCS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Immediate Cause (Final Fuilure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) 3 days Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 Yes 251No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 115107 SCHABERMAN, MD AU4176435517523 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 5. Greene St. Balt, MD tstebur SCHABELMAN ₩. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 6 2007

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1.	For State Registrar	State of Maryl		tificate of L			Reg. No.2	07	39056
Physician	1.	Decedent's Name (First, Middle, Last)	√EBB				2. Date of Dea Month Decembe	Day	Year 2007	3. Time of Death  3:43a <sup>M</sup>
/Medical Examiner	48	a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Deat	h		ity of Death  ALTIM	ORE
uneral irector		1559 BARRETT ROAL Social Security Number 6. Sex 119-20-5348	7. Age (In	yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		v, Year)	Cou	place (State or Foreign ntry) RYLAND
	11	sual Residence of Decedent  Da. State 10b. County		:. City, Town or Lo						10d. Inside City Limit
be notified be notified Director	1	MARYLAND BALTIMOF  Oe. Street and Number	RE	CATON	SVILLE 10f. Zip Code			10g. Citizen o		intry?
tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Ra Completed by Funeral Director	1	171 WINTERS LANE  1. Marital Status  1 □ Never Married 2 □ Married  3XWidowed 4 □ Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes _ ZXXIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		212 Was Decedent of H If Yes, specify Cuba 1□Yes 25No		U.S.A in? (Specify Yes or No- Puerto Rican, etc.)  14. Race Black, Specify:			, etc.
t, the Medical Extra Medical E		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking		of Business/Industry  UCATION	
other the svent, the Re Co.		8th grade  7. Father's Name (First, Middle, Last)			ATTENDAM		ame (First, Middle	Maiden Surr	name)	
Is marked of raumatic eve To Re	2 1	WILLIAM SMITH  19a, Informant's Name/Relationship (Typ.	ne. Print)	19b. Maili	ng Address (Street		ELLE ALL  Rural Route Numb		wn, State, Z	ip Code)
int: If Item 27 Is Inty or other trau	]	Barbara Scott/Daugh 20a. Method of Disposition 1⊠Burial 2 □Cremation 3 □R	nter	20b. Place of Dispo cemetery, cre	Barrett osition (Name of matory or other place	ce)	Date	20c. Location	on - City or	Town, State
Important: If II any injury or once.	-	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		T/s	FOREST 2. Name and Addre JILLIAM C 206 W NO	ess of Facility BROWN C	OMMUNITY			LS, MARYL ME P.A.
physician and sthe burial-transit	шше	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
or use a	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ Live birth   2 □ Fetal death   3 □ Ectopic					□Ectopic pregnancy □ Other (specify)			. Date of de Month	livery Day Year
be q	2	Part II. Other significant conditions co	ntributing to death but n	not resulting in the	underlying cause gi	iven in Part I.		tobacco use ]Yes 2□↑		robably 4 nkr
page 2 should	Completed							opsy formed2	24b. Were a prior to death?	
s certificate lirector, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpati	ent 3 DOA		Death <i>(Check only</i> g Home 5 ☐ Re		Other (Spe	ecify) beingth
	Certification: To	27. Manner of Death  1 Natural 2 Accident investigation 3 Suiride 6 Could not be	28a. Date of Injury (Month, Day Y		M 1[	☐Yes 2☐No		e how injury o		Rural Route Number,
within 24 hours are deam.  To the Funeral Director: A completely filled in by the f	Certific	4 Homicide determined	building, etc. (	(Specity)	ath occurred at the	time date and n	City or T	own, State)	nd manner a	as stated.
within 24 hours an  To the Funeral D  completely filled in	Medical	(Check only Medical Examone)	iner: On the basis of eand manner state	xamination and/or	investigation, in my	y opinion, death o	occurred at the tim	e, uate and p		ue to the cause(s)  nth, Day, Year)
To con	2	29b. Signature and title of certifier	Le MI	)	DI	6354		12/	5/2	2007
7		30. Name and address of person who defects the Cole ST	AGNES	th (Item 23a) (Typ	e, Print) CATON	AVE	BALTIM	ORE	MO	21229
Star Registra		31. Date filed (Month Day, Year) 20	07 32 Registrar	s Signature	parti					

DHMH 17 Rev 1/2001

07-09293 James Alan Wills Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Alan Wills	1-	State For State	of Maryland /	Depail Cert	rtment of tificate of	Health Death	and	Menta	al Hygie	ene Reg	. No. 2	0.0	7 3905
Physician/		gistrar Decedent's Name (First, Middle,Las	st)						2. Da	ate of Death			3. Time of Death
Mr Examine		JAMES ALA	N WILLS							onth I			2340 hrs
	4:	a. Facility Name (if not institution, given			41	City, Tov		ocation of	Death		4c. County o		Ì
	L	15604 Marathon Circle Ap		- (le ue le	ist birthday)	If Under		If Under	24Hrs 8.1	Date of Birth	(MM/DD/YYYY)	•	place (State or
Funeral Director	1	Social Security Number 6. S				Months	Days	Hours	1.60			Foreign	MISYLVANIA
Director	┖		XM 2 F	48	Yrs.	l				OLI A	2, 1939	PEI	NNSILVANIA
any	_	sual Residence of Decedent  Da. State 10b. County		10c. City,	Town or Location	n			-				10d. Inside City Limits
<b>*</b>		MD MONTG	OMERY	,	GAITHE	RSBU	RG					1	1 Yes 2 X No
the Maryland in or 28a-f sh	3 1	De. Street and Number		·		10f. Zip C				10	g. Citizen of Wh	nat Count	try?
with the Mai ms 23a or 28 be notified a		15604 MARATHO	N CIRCLE				087					S.A.	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	<u> </u>	1. Marital Status	12. Was Decedent		S. 13. Was	Decedent	of Hisp Cuban,	anic Origii Mexican, I	n? ( Specify Puerto Rica	Yes or No- in, etc.)		e - Americ e, etc.	can Indian, Black,
death or ite	5	X Never Married 2 Marrie	1 Yes 2	X No		Yes 2					Specify:	WF	HITE
s after ral", niner		Widowed 4 Divorce  15. Decedent's Education (Specify	or Dates:	moleted)	16a Decedent	's Usual O	ccupatio	on (Give ki	ind of work	done	16b. Kind of Bu		
"natu Exan		Elementary/Secondary (0-12)	College (1-4 or		during mo	ost of work	ing life. I	DO NOT L	use retired)		MERCA		
136 Frin 72 e. than edical	2	Elonional y Consulty (Consulty)	2	,	EXEC	UTIV	E A	SSIS	STANT		CONC	CERN	is
5-0036 led within 7 Hygiene.	Completed by	7. Father's Name (First, Middle, Las	st)		<u></u>		1				Maiden Surname		
215 be fill mital H riked	8		WILLS						ATRYC		LUTTRE		Zin Code)
21 should list man is man	₽	9a. Informant's Name/Relationship DEBRA POLLAK/											, Zip Code) 20878 DMAC, MD.
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after no of Health and Mental Hygiene, tt: If iten 27 is marked other than "natural", other trannafte event, the Medical Examiner		Oa. Method of Disposition	FRIEND	20b.	Place of Dispos					ate	20c. Location	- City or	Town, State
Ore	ľ	1 Burial 2 XCremation	Removal from S	late	crematory or oth		3 m 🔿	D.37	12/2	/07	DATEN	MOD E	MARYLAND
d = = b   <b>2.</b>		4 Donation 5 Other Speci 21. Signature of Funeral Service Lic		BAY	VIEW (				12/3		UNERAI		
Balt permit. Departs Import	1	16 hours	1 to	_//	1 1	901	EAS	TERN	AVE	NUE, B	BALTIMO	ORE,	MD. 21231
`hysician	+	23a. Part I. Enter the disease, or cor	mplications that cause	d the death	n. Do not enter t	he mode o	f dying,	such as ca	ardiac or res	spiratory arre	est, shock, or he	eart	Approximate Interval Between Onset and
/ledical		failure. List only one cause on Immediate Cause (Final disease		testina	al hemorr	hage_							Death
∠xaminer		or condition resulting in death)	Due to (or as a con:	sequence o	of):	0							
	_	Sequentially list conditions, if any, leading to immediate	b. Chronic  Due to (or as a con										
	듸	cause. Enter Underlying Cause (Disease or injury that initiated	c										
cuted Hind Hind Hind Hind	EX	events resulting in death) Last	Due to (or as a con	sequence (	ot):								
xecut n and 1 - tra	edical	XUNPENDED	a										
be be	ë   G	IF FEMALE:	AMENDED PI line 23c. If yes, outc	a b. ome of pre	PIT,27,pe gnancy	rME,g8	74,	2/24/	07_TT		23d. Date		,
6876 (certificate adding phy se as the t	ian/M	3b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death	3	Ectopi	c pregnancy	У	Month		Day Year
Box 6 e death ce the attend ed for use	Sici	1 Yes 2 No 9 Unkno		at time of d	ieath 5 O	ther (Spe	cify)						
, P.O. Box 68766 res that the death certificate signed by the attending phy be detached for use as the	Physic	Part II. Other significant condition	0	ath but not	resulting in the	underlying	cause	given in Pa	art t.	1			o the cause of death?
P.O.	Ē	Hypertensive c								1 Ye	es 2 No	3 Pro	obably 4 V Unknown
ds, requir	Completed									24a. Was auto		). Were a	autopsy findings available completion of cause of
tal Records, tian: The law requir certificate has been a	립									perfo	ormed?	death?	
I Re		25. Was case referred to medical					26.Place	e of Death	(Check on	ly one)	h		
/ita	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	itient 2	ER/Outpatier	nt 3 [	OOA	Other4	Nursing I	Home 5	Residence 6	Oth	er: Scene
of Vital Records, ing Physician: The law required After this certificate has been signeral director, page 2 should the	<b>⊢</b>	27. Manner of Death	28a, Date of I (Month, Da	njury y,Year)	28b. Time of	Injury		ıry at Wor	_	8d. Describe	how injury occ	urred	
ion tendir cath.	텵	1 XNatural 5 Pendin 2 Accident Investi	g					Yes 2					De de Number City
or At Olived in by	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Null or Town, State)							nber or F	Rural Route Number, City				
Dispital of spital of spit	determined (Specify)  4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								ated				
To the Hos within 24 h	cal	(Check only 1 Certifying Phy one) Medical Exam	sician: To the best of iner:On the basis of e	f my knowle xamination	edge, death occ n and/or investig	urred at th ation, in m	e time, c y opinio	n, death o	ccurred at t	he time, dat	e and place, an	d due to	the cause(s)
To the within To the comp	Medical	29b. Signature and title of Certifier	and manner state	ed				se numbe					fonth, Day, Year)
		1 La last	2111				0.0	.M.E.			Decemb	er 1, 2	007
<i>i</i> –		30. Name and address of person w	/ho completed cause of	of death (Ite	em 23a)								
-6		Laron Locke MD. As	sistant Medical E	xamine	r 111 Per	n Stree	t, Balti	impre, N	MD 2120	1			
	ate	31. Date filed (Month, Day, Year)	400	strar's Sign									
Regist	rar	DEC 0 6	2007		M. A.	200							

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month $P^{M}$ 2007 Jon Michael Wegrzyn Dec 1 6:02 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours Months 1 M 2 □ F 45 065-62-3133 May 26, 1962 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes XX No Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5858 Thunder Hill Rd. 21045 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 4. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXIO If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Retail Route Sales</u> <u>Westinghouse</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Wagrzyn Maureen Hailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5858 Thunder Hill Rd. B2 Columbia, MD 21045 <u> Alesia Wegrzyn (wife)</u> Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/3/2007 4 □ Donation 5 □ Other (Specify) St. Charles Cem Pikesville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility. Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory are shock, or heart failure. List only one cause on each line. Winfield, MD 21784 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cancer 11 Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1∐ Yes 2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be P MD

**Funeral** 

Director

Maryland

ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentai Hygiene. It health and Mentai Hygiene with a Tis marked other than "natural", or items 23a or 28a-f show of the than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 nent of Health a ant: If item 27 is ury or other trains

permit. Page Department o Important: If any Injury or once,

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed burial-transit and physician for detached signed be be det page 2 s

director. Hospital or Attending

Division or Vital Records, P.O. Box 68760,

lical within 24 hours after death To the Funeral Director: filled in by

Mec
Physician/
by
Be Completed
Be
은
Certification:

Examiner

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

(Check o

29a. Certifier

29b. Signatui

4 Homicide

10

completely

the

State Registrar

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Dove House

28d. Describe how injury occurred

ter Street Washinston, MID 2115

address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

1 🗌 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

Tavio Kruter

(Month, Day, Year) DEC 0 6 2007

DHMH 17 Rev 1/2001

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:25p M November 17, 2007 Anthony Auriti Augustine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 2511 Kimberly Street Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**y** M 2 □ F 578-22-6820 84 July 20, 1923 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2511 Kimberly Street 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 □ Yes 24⊡ktNo Specify:White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Counselor Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simeone Auriti Angelina Zulli 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Auriti/Son 25 Carousel Lane, Pueblo, Colorado 81001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2007 Silver Spring, Maryland $^{22}_{\mbox{\sc Name and Address of Facility}}$ Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd, W, Silver Spring. MD 20901 Part1. Enter the disease, or comshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Heart Disease Due to (or as a consequence of): Hypertension Sequentially list conditions, any tracers. It immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last More than 20 Due to for as a consequence of years Hyperlipidemia 20 Years Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner Examine death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or idical Examiner must be

r than '

s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 Is marked other th other traumatic event, the

permit. Pages 1 an Department of Hea Important: If Item any injury or othe

If Item 27 or other 1

Director

Funeral

þ

Completed

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

and Il-transit physician ar as use by the a signed l been si should b certificate has be irector, page 2 s

Physician/Medical

Be Completed by

Certification: To

Medical

this After death.

Division or Vital Records, P.O. Box 68760

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu D

or Attending

		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No  24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No									
25. Was case referred to medical examiner?	26. Place of D	26. Place of Death (Check only one)									
1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2   EPI/Outpatient 3   DOA   Other: 4   Nursing	g Home 5 🙀 Residence 6 □Other (Specify)									
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred									
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	hysician: To the best of my knowledge, death occurred at the time, date and pla miner: On the basis of examination and/or investigation, in my opinion, death or										

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howars S. Goldstein, MD 10401 Old Georgetown Road, Bethesda, MD 20814

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** LOIS SAVAGE BUTTERLY 2007 November, 20 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** KNIBULA REGIONAL 1/10/11/0 ansa 59/1564K4 If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 K F Months 222-18-7164 21, 1934 Director 73 CHIŃCOTEAGUE. VA FEB. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If teem 27 is anawaded other than "naturet", or items 23a or 28a-f show eny injury or other traumette event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director DE SUSSEX REHOBOTH BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21160 BAYVIEW ROAD 19971 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ģ Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DENTISTRY DENTAL ASSISTANT 12 Pages 1 and 2 should be filed vacue of Health and Mental Hygid ont: If Item 27 is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THURMAN F. SAVAGE ဥ NELDA **JESTER** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS J. BUTTERLY - HUSBAND 21160 BAYVIEW RD., REHOBOTH BEACH, DE 19971 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State EPWORTH U.M. CEM. 11-26-07 REHOBOTH BEACH. DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SHORT FUNERAL SERVICES GEORGETOWN, DE 19947 609 E. MARKET ST., GEORGETOWN, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hortic Valve Stenosis and Ascending Hentic 1-2- YRS. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coaquiapethy during 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Respiratory 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform Valve replacement and Aortic ANCU ISSIM Repair 16/16/07 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State

Maryland 2121

Baltimore,

Ö

Division or Vital Records.

Butte

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

DEC 0 6 2007

M. Buchness 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pine Bluff Rd.

32. Registrar's Signature

Salisbury

29c. License number

29d. Date signed (Month, Day, Year)

			For State #4.0	State of Ma							000		
Aı	mended	ite	State #18, perF.  1. Decedent's Name (First, Middle, Las		)/0/,B	.ALen	ilicate of t	Deathwor	2. Date of D	Reg. N	0. 2		3 9 0 6
· · ·	Physici		Claudia						Month			ear 7	1415 M
)	/Medio		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or		ath	4	4c. County of Death		
	and the second second		PINIASUVA REGIONAL 5. Social Security Number 6. S	Mediene	Cons		If Under 1 Year	If Under 24 H	rs. 8. Date of B	lieth		14/0	
	Funeral Director		222-30-3304	ex 7. Ag ☐ M 2 🔀 F	je (In yrs. la: 96		Months Days	Hours M		Day, Yea -191	1 9	Countr	ce (State or Foreign WARE
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loca	ation			·		10	d. Inside City Limits
	Maryl Ff sho	tor	DELAWARE SUSSE	X		FRANKI	FORD						1 ¥ Yes 2 □ No
	th the or 28a e noti	Director	10e. Street and Number		1		10f. Zip Code			10g. C	Citizen of Wha	at Countr	y?
	ath wi		248 CLAYTON AV				1994	-			ITED S		
936	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,		as Decedent of H Yes, specify Cuba ☐ Yes 2X No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Black, Specify:	White, e	
2-0	72 hou natura lical E	sted	15. Decedent's Ed (Specify only highest gra				ent's Usual Occup		vorkina	16b.	Kind of Busin	ness/Indu	istry
21215-0036	be filed within 72 hortal Hygiene. d other than "natuevent, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	O NOT use retired IOMEMAKEI	1)	· · · · · · · · · · · · · · · · · · ·		NON	Æ	
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	ı					lame (First, Middi	le, Maide			
lan	should be fand Mental I	To Be	JOSEPH LYNCH					SALI	Y Meabe	Sa	.11y Mc	Cabe	2
Maryland	2 should be filed v n and Mental Hygie Is marked other t raumatic event, th		19a. Informant's Name/Relationship (	Type. Print)		-	Address (Street						
	百華にす	v - s	JANET B. DAVIDSON	N/ DAUGHTE			MAIN ST	REET, D	AGSBORO,				
Baltimore,	Page ent o nt: If		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	1)	C	EMETER	ition (Name of atory or other place		-21-2007	FR		•	ELAWARE
Bal	permit. P Departm Importar any inju		21. Signature of Funeral Softice Local	Melso			LATCHER S					45	
S.	Physician		23a. Part1. En er the disease, or come shock, or heart failured at only Immediate Cause (Final disease or condition	plications that cause one cause on each li	d the death. ine.		r the mode of dyir			arrest,			Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as	a conseque								
	Examiner	<u>.</u>	Sequentially list conditions,	b Due to (or as	2 00000000	ence of):							
	uted Insit	Examiner	if any, leading to immediate  Cause (Disease or injury that initiated events	Due to (or as	a conseque	silve oi).							
o,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):							
8760,	ate be hysicii the bu	dical		.d								_	
9	leath certific attending p I for use as i	/Mec	IF FEMALE:	23c. If yes, outcome	o of oregon	icv							
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 □	Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of Month		y Day Year
	res that the de signed by the a be detached i	by Ph	Part II. Other significant conditions	ontributing to death b	out not resul	ting in the und	derlying cause giv	en în Part I.	23e. Dio	d tobacc	o use contrib	ute to the	e cause of death?
ords	v require been sig should b	ed b	Hypenens.o	y Bhen	marla	-A b.	thods		_ 10	Yes	2 No 3	☐ Proba	ably 4 □Unknown
Records,	law requias been	Completed							_ 24a. Wa	as an topsy			sy findings available ipletion of cause of
al H		Son							pe 1⊟ Yes	rformed?		ath? ]Yes :	2 □ No
Vital	Physician: The lav this certificate has ral director, page 2	Be o	25. Was case referred to medical examiner?	Hospital:		'D'(O. to ation t	3D DOA Oth	or:	Death (Check only				
O		n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ury	R/Outpatient 28b. Time of	3 □ DOA   Stri	4 LI Nursin	g Home 5 ☐ Re 28d. Describ				)
ion	Attending r death. ector: After by the funer	atio	1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investigation		ay rear)	Injury		Yes 2 □ No					
Division	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location City or 7	(Street own, Sta	and Number ate)	or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and manner st	of examinati	rledge, death on and/or inv	occurred at the ti estigation, in my	me, date and plopinion, death o	ace, and due to the courred at the time	ne cause ne, date a	e(s) and manr and place, an	ner as sta id due to	ated. the cause(s)
<b>N</b>	To the within 2 To the complei	Me	29b. Signature and title of certifier	0.0			29c. Licens ککرک	e number			Date signed (		Day, Year)
	0.4		30. Name and address of person who	completed cause of	death (Item :	23a) (Type, F	Print)						
	BA 10		Michael E. O	on Jouch	, 10	5 Pins	Brutto S	4=7, Sal	robus +	103	51801		
	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 1 20	32. Begist	rar's Signati	re Apr	Brust, S						
DH	IMH 17 Rev 1/2	001											

		For State	State of I	Maryland / De	partment of Fertificate of			200	7 39062		
		Registrar  1. Decedent's Name (First, Middle,	, Last)		ertificate of	Dealli	2. Date of Deat				
Physic /Medi		Ella Mae Bau	erlien				November	r 18 2007	8:50 a M		
Exami		4a. Facility Name (If not institution,	-			or Location of Death		4c. County of Death			
		Carroll Hospice  5. Social Security Number		Se Age (In yrs. last birthd		tminster  If Under 24 Hrs.	8. Date of Birth	Carr	rthplace (State or Foreign		
Funeral Director		219-20-4530	1 M 2 M F	82 Yrs	Months Days	Hours Min.	June 09	Year) C	Country) MD		
0		Usual Residence of Decedent		100 City Town o	Location						
larylar show	h	10a. State 10b. County  MD Ca	rroll	10c. City, Town or					10d. Inside City Limits 1 XYes 2 ☐ No		
the N 28a-f notifie	Director	10e. Street and Number	TIOII	west	minster 10f. Zip Code		10	0g. Citizen of What C	country?		
ING 21215-0036  be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	io ie	62 Timber Ridg	ge Drive			1157		USA			
ems 2	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	3. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh			
36 s after or to	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give	<b>©</b> No	1 ☐ Yes 2 No		, , , , , , ,		White		
hours hours		15. Decedent	Year or Date	16a. De	ecedent's Usual Occu	pation		16b. Kind of Busines	s/Industry		
215 hin 72 an "na Medic	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4)	or 5+)	live kind of work done le. DO NOT use retire		king				
d 212' filed withir Hygiene. other than ent, the Me	Completed	8			Service A			Random H	ouse		
eve d all be	Be	17. Father's Name (First, Middle, L Howard Eswor	,				ne (First, Middle, M et Black	,			
arylishould med Me mark	2	19a. Informant's Name/Relationsh		19b. M	ailing Address (Street				Zip Code)		
e, Mc 1 and 2 Health a em 27 is	П	Linda Gray/Daug	hter		Glyntree		eistersto	wn, MD 2	1036		
2 8 2 E 2		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from Sta	20b. Place of Di cemetery,	sposition (Name of crematory or other pla	11/2	21/200/	20c. Location - City o			
E Pa Fire		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L			en Memoria Privotes d'Autori			Finksburg	• •		
Balti permit. Departr Importa any Inju	1	I Signature of Fulleral Service L	. Cerispe		412 Washir	ngton Road	d Westmi	inster, MD	21157		
4		23a. Part . Enter the disease, or shock, or heart failure. List of	complications that cau	sed the death. Do not					Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition	_a B;1	iary ob.	struction				Onset and Death		
/ /Medical Examiner		resulting in death)	,	as a con equence of):	uterine	Ca					
	- e	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury	U	es a consequence of):	rerine	cancer					
cuted nd ransit	Examiner	l triat itilitateu everris	c								
18760, cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or	as a consequence of):							
68760 ficate be e physician is the buria	dical		d								
Box 6 eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		3 □Ectopic pregnanc			23d. Date of d	elivery		
ecords, P.O. Box 63 law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		it at time of death	5 ☐ Other (specify) _	<u>-</u>		Month	Day Year		
P.O. hat the de	Phy	9 ☐ Unknown  Part II. Other significant conditio			e underlying cause di	ven in Part I	23e. Did toh	pacco use contribute	to the cause of death?		
VITAI HECONDS, P iclan: The law requires that certificate has been signed trector, page 2 should be deti	d by	Non		_	- a g		1 □ Ye	es 2∐No 3∐I	Probably 4 Dunknown		
w red	lete						24a. Was a	n 24b. Were	autopsy findings available		
VITAI REC sician: The law certificate has l	Completed						autops perforr 1□ Yes 2	prior to med? death? 2.2 No 1 ☐ Ye	o completion of cause of es 2 No		
/Ita	Be C	25. Was case referred to medical examiner?					th (Check only on				
Or \ Physical this o all dire	은	1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2 ER/Outpa	ment olipox			ence 6 Other (Sp	pecify) /40 Spice		
DIVISION OF  I or Attending Physafter death.  Director: After this d in by the funeral di	tion:	1 Natural 5 Pending 2 Accident investig	(Month,	Injury 28b. Tim Day Year) Inju	ry Wo	irk? ]Yes 2∐No	26d. Describe no	ow injury occurred			
IVISIC or Attend ter death lirector: n by the f	ifica	3 Suicide 6 Could not determine	ot be 28e. Place of	injury - At home, farm , etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or i	Rural Route Number,		
rs affe	Certification:	4 - Homeide	Dullding	, etc. (Opechy)			City of Town	i, Siate)			
Hosp 24 hou Fune rtely fil	edical			est of my knowledge, d is of examination and/o							
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it	Med	29b. Signature and title of certifier	and manne	saled.		se number	2	9d. Date signed (Mo.			
har		> boad &	aint "	4, D.		15552		11/201	07		
10)		30. Name and address of person v	who completed cause	of death (Item 23a) (Ty	pe, Print)	te. It	8.7 h	Jestmin.	ster, 4d. 21153		
St	ate	31 Date filed (Month Day Year)	32 Ren	Atrar's Signature					,		
Regist		NOV 2	0 2007	losva St	Sperke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIP #10b, per H, (\$8/8, 5/2/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jennie BLOND **Physician** 19, 1:13 P M 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Mar. 17 6. Sex **Funeral** Year Country) Russia Months Days Hours Min 1 M 2 F Mar. Director 143-03-9329 95 1912 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State Prince George's 10d. Inside City Limits 'natural", or Items 23a or 28a-f show Examiner must be notified at Takoma Park Maryland 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1601 Drexel Street 20912 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Window Decorating Custom Window Decorator Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Lopatin Ida Raisky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 357 East Alameda Street, Santa Fe, NM David Blond, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/25707 permit. Pages 1
Department of H
Important: If Ite
any Injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial Gården Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Le. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-tra-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No. Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 🗆 Unkno by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performe certificate 25. Was case referred to medical Be 26. Place of Death (Check only on examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient 1 TYes 2 No 2 ER/Outpatient 3 DOA P 27. Ma er of De th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Year (Month, Day Natural 2 Accident 1 ☐ Yes 2 ☐ No Funeral Director: tely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 t To the Fur (Check only 29d. Date signed, (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 repleted cause of death (Item 23a) (Type, Print) 7600 Carrol 30. Name and address of person 31. Date filed (Month, State 21

DHMH 17 Rev 1/2001

Registrar

NOV

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year

7. Age (In yrs. last birthday)

10c. City, Town or Location

Hagerstown

76

4b. City, Town, or Location of Death

Hours

Hagerstown If Under 1 Year | If Under 24 Hrs.

Days

10f. Zin Code

November

8. Date of Birth (Month, Day, Year)

12/26/30

2007

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☑ Yes 2 ☐ No

MD

Washington

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: white

23d. Date of delivery

1 □Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Month

**Physician** /Medical Examiner **Funeral** Director show 1 r 28a-f sho notified a Director

Norma Lee Calhoun

4a. Facility Name (If not institution, give street and number)

10b. County

5. Social Security Number

10e. Street and Number

10a. State

MD

234-48-3067

Usual Residence of Decedent

Washington County Hospital

1 □ M 2 🛛 F

6. Sex

Washington

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ral", or items 23a or Examiner must be Baltimore, Maryland 21215-0036 'natural", or tem 27 is marked other permit. Pages
Department of I
Important: If it
any injury or o
once.

> **Physiclan** /Medical Examiner

> > and attending physician the þ has this certificate funeral After

Box 68760,

or Vital Records, P.O.

The law requires that the death certificate be executed Attending Physician: within 24 hours after death To the Funeral Director: filled in by Hospital

21742 U.S.A. 18641 Crestwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12th homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice S. Clark Brook Preston Bodkin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18641 Crestwood Drive, Hagerstown, MD 21742 Robert E. Calhoun/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition ₩₩Burial 2 Cremation 3 Removal from State Queen's Point 11/27/07 Keyser, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Markwood Funeral Home, Inc. Harly Dean Notes P.O. Box 912. Keyser W

23a. Part1. Enter the disease, or complications that care depth death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 912, Keyser WV 26726 Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examiner enon by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed autopsy performed 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 - Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 v ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 60228 NOU 23 Hagerstown Maryland 30. Name and address of person who completed cause repeath (Item 23a) (Type, Print) 12821 Oak Hill AUC Ahmed

DHMH 17 Rev 1/2001

12

State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Blake Michael Crampton 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year November 19, 2007 1613 hrs Blake Michael CRAMPTON Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown 440 Liberty Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Foreign Min Months Davs Hours Country) Maryland March 25,1985 Director 214-17-9205 22 Yrs 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Hagerstown Maryland Washington with the Maryland 10g. Citizen of What Country? 10f. Zip Code Direct 10e. Street and Number USA 21740 440 Liberty Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Pages 1 and 2 should be filed within 72 hours after death 1 X Never Married 2 Married 2 X No Yes Specify: white Yes 2 X No specify: 4 Divorce If Yes, Give Year Widowed "natural" δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed building College (1-4 or 5+) Elementary/Secondary (0-12) trent: If item 27 is marked other than or other traumatic event, the Medical the Medical 21215-0036 construction 0 laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cheryl May Tritch Michael Leon Crampton Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD Hagerstown, Md. 21740 - sister Knightsbridge Dr., Chelby Taylor Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 11/23/07 Hagerstown, Maryland Hagerstown Crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses E. Wilson Blvd., Hagerstown, Md. 21740 415 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death Medical a. Head Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Fetal death Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknowr the signed by the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 V No 3 Probably 4 Unknown 3 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate has performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 this 1 ✓ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work 28b. Time of Injury After 27. Manner of Death Certification: Subject assaulted FOUND: Natural 1 Yes 2 ✔ No 5 Pending Director: Nov 19, 2007 1607 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 440 Liberty Street, Hagerstown, MD Suicide determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 20, 2007 O.C.M.E and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mélissa Brassell, MD 32. Registrar's Signature 31. Date filed (Mo State Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0915(AM 2007 /Medical 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner McCread Hospital Memoria ristie 12 V loysland Jonevset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. 54 5. Social Security Number 9. Birthplace (State or Foreign Funeral Months 1XXM 2□ F Director 21, 1953 Germany 212-64-5793 April Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notifled at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be 21817 USA 3470 Lawsonia Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 □ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Roofer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Franklin Coffey Margaretha Schoen ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3470 Lawsonia Road - Crisfield, Maryland 21817 Betty Eileen Ribble Coffey (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ②CCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 11/26/07 Salisbury, Maryland 21. Si n'thr of Funer, Service Levee

Mary Beth Bradshaw-Pruitt

22. Name and Address of Facility

BRADSHAW &

306 W. Main Street - Crisfie

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 Immediate Cause (Final disease or condition resulting in death) Atherosclerotic 1,5 case **Physician** 7 loyear /Medical Due to (or as a consequence of) Examiner 015 iabetes Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nicotine abo or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit P.O. Box 68760, Physician/Medical VCDa as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ 2 Fetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death signed by the a 9 I Inknown 9 Unknown Part IJ-Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by cate has been sig page 2 shoufd b 2□ No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate ! 2 46 1∏Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 R/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ko bert Kly, Mn Nov 24, 200+

State Registrar

DHMH 17 Rev 1/2001

NOV 2 6 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



emenal Hospital

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ARland 200 /Medical 4c. County of Death Facility Name (If pot institution, give street and number) 4b. City, Town, or Location of Death Examiner Byrd risfield Nursing Home Alice omerset lawes 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-15-1914 9. Birthplace (State or Foreign **Funeral** 212-14-4481 Months Days ろ Hours Country) 9 MD Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits MD ristico 1XYes 2 No **Funeral Director** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with "natural", or Items 23a or edical Examiner must be 21817 309 Richardson 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ۾ 3 Widowed 4 Divorced Year or Dates Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Self EployEd Elementary/Secondary (0-12) College (1-4or 5+) BarbER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Marion Cottman Cottman 2 ouise. 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Chesapeake Are. Cristicald VERNEL MD 21817 ( DH man 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Hopewell Cometery 11-24-07 Hopewell, 4 Donation 5 Dother (Specify) 22. Name and Address of Facility An Thony E. Ward Funeral Hemo 21. Signature of Funeral Service Licenses Ward Hury risticid COUE ST. 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OF AMPULLA CANCER OF VATER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy signed by the atte in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2**1** No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 2K No 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Mapner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regi State NOV 2 1 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 For State State Registra MFND#31, See#3211/21/07, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $p^{\mathsf{M}}$ Joyce Ε. Conlon November 14, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral 1 □ M 21€ F Months 391-70-5482 Director 50 April 30, 1957 Virginia Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d, Inside City Limits 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 19051 Highstream Drive 20874 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced 'natural", Year or Dates: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 Is marked other than Systems Programmer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Conlon 2 Yvonne Gallant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Vogt / Companion 19051 Highstream Drive, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Pages ' Department of H Important: If ite any injury or ol once, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/19/2007 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease shock, or heart failure.
Immediate Cause (Final Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** a Intracranial Hemorrhage 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner executed that initiated events resulting in death) Last and as the burial-trai Due to (or as a consequence of): attending physician or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month 5 Other (specify) ☐Yes 2X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24a. Was an

certificate After

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Completed by Be Certification: To To the Hospital or Attendir, within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

autopsy 1 Yes 2 X No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 X No 27. Manner of Death 5 Pending investigation 1 X Natural

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? Injury 1 □ Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only

2 Accident

3 ☐ Suicide 4 Homicide

> 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Oinfoy clay , M.D. 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHENG

QIUFANG 31. Date filed (Month, Day, Year)

32. Registrar's Signature NOV 2 1 2007

M.D

4901 Medical Center Drive, Rockville, MD 20850

State Registrar

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 10:15<sup>a M</sup> Maurice Collins William November 19, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3122 Beltsville Road Beltsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 7, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 🖫 M 2 🗆 F 578-38-7792 76 Yrs 1931 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 TNo Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3122 Beltsville Road 20705 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1∑Yes 2 No If Yes, Give 1953-55 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ SpecifWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Educator/Coach Catholic High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Joseph Collins Catherine Sheahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Collins/Wife 3122 Beltsville Road, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 24, 4 Donation 5 Other (Specify) Mount Olivet Cemetery 2007 Washington, DC 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac Arrest disease or condition resulting in death) Due to (or as a consequence of): Coronary Artery Disease 30 years Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an

**Physician** /Medical **Examiner** 

**Funeral** 

Director

Show

item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

al Hygiene.

permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 is marked oth
any Injury or other traumatic event

death with the Maryland

filed within 72 hours after

Saltimore, Maryland 21215-0036

death certificate be executed

attending physician and for use as the burial-tran signed by the a has been To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Be

P

Certification:

Medical

Division or Vital Records, P.O. Box 68760

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy

							1⊟ Ye	s 2√1 No	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							ly one)	
1 Yes 2 No	Hospita	al: 1 □ Inpatient 2	☐ ER/Outpatient	3 🗆 [	AOC	Other: 4 Nursing Home 5 Residence			
27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Descrit	oe how injur	

sidence 6 Other (Specify) e how injury occurred

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated.

29b. Signature and titl	e of certifier
1 Per	- July

29c. License number D33067 29d. Date signed (Month, Day, Year) November 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Gallino, MD 106 Irving Street, NW, Washington, DC 20010

State Registrar 31. Date filed (Month, Day, Year) NOV 21 2007



X

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:15ам Kim Man Ho Cheng November 2007 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4405 Bestor Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Days Hours Min. 97 September 23, 1910 China 215-84-4166 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4405 Bestor Drive 20853 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Completed by 3 Nidowed 4 Divorced Asian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary School 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Y. L. Ho Young Ho 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Department of H Important: If ite any Injury or ot

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed

peen

has

P.O. Box 68760

Division or Vital Records,

or Attending Physician:

To the Hospital

**Funeral** 

Director

28a-f show at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or Items 23a or.

3altimore, Maryland 21215-0036

Examiner must be notified

the Medical

Examine attending physician and for use as the burial-tran Physician/Medical signed by the at d be detached for Completed by director, Be P within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of Certification:

25. Was case referred to medical 27. Manner of Death

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. imme land Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FFMALE ☐Yes 2 🖾 No 9 Unknown

20a. Method of Disposition

21. Signature of Funeral Sirving

Virginia W. Mok - Daughter

4 Donation 5 Other (Specify)

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☑ No

29b. Signature and title of certifier

1 X Naturai

2 Accident

23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 4□Pregnant at time of death

1 🔲 Inpatient

(Month, Day Year)

28a. Date of Injury

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Sudden Cardiac Death, Arrhythmia

Coronary Artery Disease

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

3 □Ectopic pregnancy

28c. Injury at Work?

29c. License number

MD25285

1 ☐ Yes 2 ☐ No

23d. Date of delivery Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

November 16, 2007

20c. Location - City or Town, State

Rockville, Maryland

23e. Did tobacco use contribute to the cause of death?

24a. Was an

4405 Bestor Drive, Rockville, Maryland 20853

Date

11/24/2007

11800 New Hampshire Avenue, Silver Spring, Maryland 20904

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Approximate Interval Between Onset and Death

Immediate

Unknown

autopsy performed' 1∐ Yes 2⊠No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M.D 30. Name and address of person who completed caus f death (Item 23a) (Type, Print)

Paul P. Chang, M.D., 2150 Pennsylvania Avenue, NW, Washington, D.C. 20037

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 21 2007

5 ☐ Pending investigation



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:06 AM Catherine Florence Dorsey 23,2007 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Hagerstown Washington 17327 Gay Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 ☐ M 2 💢 F 219-20-1444 84 Maryland Director Nov. 16, 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 17327 Gay Street 21740 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Monce. Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Amelia Bitner Grayson David Staley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17329 Gay Street Hagerstown, Maryland 21740 Patsy Boward - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | 11-26-2007 | Hagerstown, Maryland 21. Signature of Juneral S 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician an s the burial-tr Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Ves W No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2€ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes No has e 2 this certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 🚱 No 2 ER/Outpatient 3 DOA ပို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Il Director: After to in by the funeral Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

SH-3

State Registrar

Zera NOV 2 31. Date filed (Month) 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennsylvania 13424 32. Registrar's Signature

		•	For State Registrar	State of Marylar		rtment of H		F	Reg. No.	07	39072	
	Physici	an	1. Decedent's Name (First, Middle, Last)  Leste	DAMO	LTH			2. Date of Dea Month	Day 5	Year () 7	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give st Westminster Nursin	reet and number)		4b. City, Town, or Westmin	r Location of Death ster		4c. County Carr	of Death		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/1/19	h /, Year) 25	9. Birthpi Coun Mary		
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loc	ation					Od. Inside City Limits	
	Maryli -f eho	tor	Maryland Carroll	На	mpstead						1 ☐ Yes ŽÕNo	
	or 28a	Funeral Director	10e. Street and Number	7		10f. Zip Code			10g. Citizen of United		•	
	eath w	eral	3820 Sunnyfield Ct.	2. Was Decedent Ever in U	J.S. 13. W	21074	lispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americ	an Indian,	
980	d within 72 hours after death with the Maryland plane. Jane. Than "natural", or items 23e or 28e-f ehow The Mudicul Exanami must be notified at	Completed by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	If	Yes, specify Cuba ☐ Yes 2 XNo	an, Mexican, Puerl Specify:	o Rican, etc.)	Specia	rck, White, fy: Wh	aite	
21215-0036			15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation co <i>mpleted)</i> Coll <b>ege</b> (1-4or 5+)	(Give k	O NOT use retired	during most of wor		16b. Kind of E			
d 21	il Hygier other th		17. Father's Name (First, Middle, Last)		Retire	d Truck		ne (First, Middle,	Truckir Maiden Sumai		фану	
lan	should be ind Mental I	To Be	Lester E. Damuth S	r.			Reba P					
Mar	nd 2 sh alth and 27 is rr r traurr		19a. Informant's Name/Relationship (Type Helen D. Damuth —		19b. Mailing 3820	Address (Street Sunnyfie	and Number or Rueld Ct. A	pt. 2A H	er, City or Town Iampstea	ad, MI	Code) D 21074	
Baltimore,	0 0		20a. Method of Disposition  1 XBurial 2 Cremation 3 Re  4 Donation 5 Other (Specify)		Place of Dispos cemetery, crem rergreen	ition (Name of atory or other place Memoria	al 11/1	Date 9/2007	20c. Location Finksbu	•	<sub>wn, State</sub> Iaryland	
Baltir	permit. Pege Depertment of Important: If any injury or QUICE.		21. Signature of Funeral Service License			Name and Addre	et Hampst	line Fur			34 South	
	16		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death									
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		Tic	LUNG	Car	1 CLB		1 years	
	ped isit	ilcal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last  C.  Due to (or as a consequence of):									
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit											
9	rtificat ng phy s as the	Medi	IF FEMALE:									
О. Вох	he death certific the attending p thed for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23b. Was decedent pregnant at time of death   5   Other (specify)   1   Yes 2   No 9   Unknown   1   Unknown   1   Unknown   1   Yes 3   Yes 3   Yes 4   Pregnant at time of death   5   Other (specify)   1   Yes 4   Yes 5   Yes 5   Yes 5   Yes 5   Yes 6   Yes 6   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 7   Yes 8   Yes 9   Yes 9					/			23d. Date of delivery Month Day Year	
<u>a</u>	law requires that the de as been signed by the : 2 should be detached	þ	Part II. Dther significant conditions con	nbuting to death but not re	sulting in the un	derlying cause giv	ven in Part I.	23e. Did to			ne cause of death?	
Records,	0 5 0	Be Completed						24a. Was autop perfo		prior to co	psy findings available mpletion of cause of 2 No	
Vital	icien: Th certiticate rector, pag		25. Was case referred to medical examiner?				26. Place of De	ath (Check only o				
of V	Physicien: this certificated rail director,	10	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Reside								
	ling Atter	tlon:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor M 1	ryat rk? ∣Yes 2∐No	28d. Describe	now injury occu	med		
Division	I or Attending atter death. Director: Atter d in by the tune	Certification:	2 Accident					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospite 24 hours Funerel stely tilled	edical C	29a. Certifier 1 Certifying Phys (Check only one) 1 Certifying Phys	cian: To the best of my kr er: On the basis of examin and manner stated.	nowledge, death lation and/or inv	occurred at the ti estigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and n date and place	nanner as s	tated. the cause(s)	
	To the Hos within 24 h To the Fun completely	S 296. Signature and title of certifier 29d. Date signed (Month, L						Day, Year)				
)	ber		John W.	Name and address of person who completed cause of death (Item 23a) (Type. Print)  Tomical Milleton 688 Pooke Rd Westminster, MD 211						15, 2007		
3	Y VA		30. Name and address of person who co	npleted cause of death (Ite	om 23a) (Type, I	onto P	of lis	ston is	tor	MI	21157	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		1 / 00		150			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3:19 PM 2007 Jerome Dunham Nov. 15. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2 □ F 75 Sep. 5, 1932 Savannah, GA Director 259-40-3176 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 □ No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 U.S. 2005 Ballows Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1953–73 Year or Dates: 1953–73 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 k Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than "natur aumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Programmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betsy Snype Adam Dunham ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other trauonce. Silver Spring, MD 20906 2005 Ballows Way Jack Dunham / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. Dec. 6, 2007 4 Donation 5 Dother (Specify) Arlington, VA 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses Inder. Thompson 7400 Georgia Ave., N.W. Washington, D.C. 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence o) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of designing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy performed?

1 Yes 2 No certificate director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 1 4mpatient 2 ER/Outpatient 3 DOA After this funeral dir P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending To the Hospitan ... within 24 hours affer death.

To the Funeral Director: Affermetely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 116/2007 130061681 MP 30. Name and ress of person who completed cause of death (Item 23a) (Type, Print) 18101 Write, olner opert 31. Date filed (Month, Day, Year) gistrar's Signature State NOV 21 2007 Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** November 17, 2007 1:35A <sup>™</sup> Kumar Dass Sudhir /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Takoma Park Washington Adventist Hospital Montgomery if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 84 1923 India FEB. 1, Director 218-57-2536 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene.
ther than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Nem 27 is marked other than "natural", or Nems 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐XYes 2 ☐ No Prince George's Adelphi Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 8711 23rd Court 20783 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Teacher</u> Education permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Basanti Mukuti Moni Chandra Dass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23rd Court, Adelphi, Maryland 20783 8711 Aruna Nowrangi - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. 11/25/07 Adelphi, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home inc.
11800 New Hampshire Ave. Silver Spring, MD 20904 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1 Fint the disease, or complications that caused the d at shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a g Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examine certificate be executed ed by the attending physician and detached for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by to the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other signification Division or Vital Records, Completed by 1 Yes 2 No 3 Probabiy 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes To the Hospital or ... within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 2 No 1 Inpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie. Medical (Check one) 2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Takoma Park, MD 20912

7600 Carroll Ave,

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nassreen Kango,

NOV 2 1 2007

31. Date filed (Month, Day, Year)

State Registrar

511-7

altimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

20311

Begistrar's Signature

D44996

opans Rd Bonsboro Mp 21713

29d. Date signed (Month, Day, Year) November 23, 2007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mon

M.D.

's Signature

angi

	ſ		For State Registrer	State of	Maryland		artment <i>rtificate</i>			nd Me	ental Hyg	jiene	007	39078
			1. Decedent's Name (First, Middle,					-			2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		Grace	Laraine	EDLUND	)	,			1	Novembe	r 23	2007	2:50 bm
	Examir		4a. Facility Name (If not institution,		ber)		4b. City, To			Death			ounty of Death	
			11416 Greenberry 5. Social Security Number 6		Ann /In un I		Hag	erst	OWN If Under 24	4 Hre	C. Data of Birth		shingt	
	Funeral Director		082-20-2648	1 M 2 X F	. Age (In yrs. la 78	Yrs.				Min.	8. Date of Birth (Month, Day Dec. 28			place (State or Foreign intry)  York
			Usual Residence of Decedent				<u> </u>				Dec. Zo	192	o New	TOLK
	rylan		10a. State 10b. County			, Town or Lo								10d. Inside City Limits
	th the Marylar or 28a-f ahow e notified at	cto	Maryland Washing	gton	Над	erstor								1 ☐ Yes 2y⊟yNo
	with the	Die	10e. Street and Number	. Dood			10f. Zip C	217	<i>(</i> .0		1		on of What Cou	intry?
	eeth ne 23.	era	11416 Greenberry	12. Was Deced	ent Ever in U.S	S 13	Was Decede			in? (Snec	cify Yes or No-		I. Race - Amer	ican Indian
9	72 hours after deeth with the Maryland naturer, or tieme 23e or 28e-f ahow idical Examiner must be notified at	/ Funeral Director	1 ☐ Never Married 2 🛱 Married	Armed Force	es?		If Yes, specif		Mexican, I Specify:	Puerto P	cify Yes or No- lican, etc.)		Black, White Specify:	
8	"naturaf",	To Be Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:									
5	C 20	siete	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of work DO NOT use	done dui retired)	ring most o	of workin	g	166. KING	d of Business/li	idustry
212	filed within Hygiene. other than "	E	Elementary/Secondary (0-12)	College (1-4	for 5+)		owner					trop	hy sho	р
ğ	be filed v tal Hygie d other i	3e C	17. Father's Name (First, Middle, La					1.	8. Mother's	s Name	(First, Middle,			
<u>yla</u> ı	2 should be and Mental ris marked o	2	Frank	Wese]	L						Helen	Yeng		
Maryland 21215-0036			19a. Informant's Name/Relationship M. Louis Edlund				-				Route Number			
	s 1 and 2 of Heath a Itam 27 is		20a. Method of Disposition	- Ilusbanc	20b. PI	lace of Dispo	osition (Name	e of	Ly KO		ite lagers		ation - City or T	
JOE .	Pages ent of nt: If li		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate		matory or oth wn Crei		rv	oveml		Наое	rstown.	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lie		1146		2. Name and				,2007    nnich			
m	Depa Impo any i		Or about B	Roch	· 	4:	15 E.	Wilso	on Bl	.vd.,	Hager	stown	n, Mary	land 21740
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau ily one cause on eac	used the death ch line.	. Do not ent								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	- FWD	171/51	EMA	· Ct	t Pd	NIC	13	RONC	175	74.	VEAZS
	/Medical Examiner		resulting in death)	Due to (or	r as a consequ	ence of):			-/Wi					1=125
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	r as a consequ	uence of):	-y pu	VI	_/ V V \					yem?
	cuted	Examiner	triat initiated events	C.			•							
0,	ate be executed hysicien end the burial-transi	Ex	resulting in death) Last	Due to (or	r as a consequ	ience of):								•
8760,	icate be executed physicien end s the burial-transit	Physician/Medicai		d										
9 x	certifi Iding I	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnar	ncv						23	ld. Date of deliv	/AD/
Box	death e etter d for c	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnar	th 2 ☐ Fetal nt at time of de		☐Ectopic pred ☐Other (spec					20	Month	Day Year
P.O.	by the	hys	9 Unknown	9□ Unknow	vn .						1			
<u>s</u> , F	res the igned be de	6	Part II. Other significant condition	contributing to dea	th but not resu	Ilting in the u	nderlying car	use given	in Part I.			_		the cause of death?
0.0	requi	eted	->901711100	2 66 11	7	LIAA		01			10%			
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires thet the death certific within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending pl completely filled in by the funeral director, page 2 should be detached for use as	Completed				TICUH	1,				24a. Was a autops perform	med?	prior to o death?	opsy findings available ompletion of cause of
tal	en: T tificetu tor, pa	BeCc	25. Was case referred to medical					2	6 Place o	of Death	1 ☐ Yes (Check only or	2M No	1 🗆 Yes	2 No
Ž	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 1 Inp	patient 2 1	ER/Outpatier	nt 3 DOA	Other			. /		Other (Spec	ify)
0	ng Pt fter th		27. Manner of Death 1 Deatural 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	1 28	c. Injury a Work?	t	2	8d. Describe h	ow injury	occurred	
Sio	tandi leath. tor: A the fu	cati	2 Accident investigal 3 Suicide 6 Could no	he			М		s 2 No					
Οį	for At efter of Diraci	Certification:	4 Homicide determin	ad 286. Place o	f Injury - At ho g, etc. (Specify	me, farm, sti	reet, factory,	office		2	8t. Location (Si City or Town		Number or Rui	al Route Number,
_	papita hours inaraf y filled	aic	29a. Certifier Pertifying	Physicien: To the b	est of my knov	wledge, deat	h occurred at	t the time,	date and	place, ar	nd due to the c	ause(s) a	nd manner as	stated.
	the Ho in 24 the Fu spletel	Medicai	one)	aminer: On the bas and manne	is of examinat or stated.	ion and/or in	vestigation, i	n my opin	ion, death	occurre	d at the time, d	late and p	lace, and due	to the cause(s)
	To Too	2	29b. Signature and title of certifier	1-1	100		29c.	License n	number	MI.	>   4	9d. Date	signed (Month	Day, Year)
			20 Name and address (V)	ni V	JU () J	14	- I.	700	2	4	5	<u>l</u> \	1991	J /
951	1-3		L., Wight Wo	Ster IIII	O MKO	IQU C	anipl	LS RC	1. H	000	Stown	MD	2174	}
	Sta Registr		31. Date filed (Mohth, Day, Year)	2007 32. Re	istrar's Signat	ture	Lucks			J				
					The same of	Man Man								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death November 23 2007 **Physician** Evans VI ARion /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SALISBUIL Regional Medica Center NICOMIO If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7 Oyrs. 32-9658 1□M 2**X**F Days Hours 08-18-MD 1937 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at risfield MD 1 Yes 2 No Funeral Director OMERSET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 253 Somers COVE 21817 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 → Married Maryland 21215-0036 1 ☐ Yes 2125-No Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Scatood, Inc aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Somers ristiald. Argenche E. Jones - Daughtel 20a. Method of Disposition | 20b. P Cove MD 21817 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 12-01-2007 Marion, MD Peer Cemaling 4 ☐ Donation — 5 ☐ Other (Specify) 22. Name and Address of Facility Anthony E. Mard funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 314 Cove ST. Crisfield, UD 21817 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Hypoxemia

Due to (or as a consequence of): **Physician** dou /Medical Examiner Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of Examiner Due to (or as The law requires that the death certificate be executed ending physician and use as the burial-transit tm Phy Sema Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown protein calorie malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2⊿No Alcholism 2□ No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes 2**7** No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060715 November 23 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 , Jeyed A. Jalah loo East corroll Salisbuy, MD ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**ORIGINAL** 

DHMH 17 Rev 1/2001

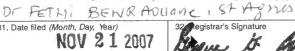
Registrar

NOV 2 6 2007

			1 - For State Registrar	State of Mai		artment of F <i>rtificate of</i>	lealth and M <i>Death</i>		iene 00	7 39080				
	Dhucini		1. Decedent's Name (First, Middle, La	•				2. Date of Death	h	3. Time of Death				
,	Physici /Medic		Gene Marshall FII			1		Novembe	er 21, 20	007 8:55 a. M				
	Examin	er	4a. Facility Name (If not institution, giv 810 Beaver Creek	·			or Location of Death		4c. County of Death					
Н	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year		8. Date of Birth	Washington of Birth 9. Birthplace (State					
	Director		218-38-1163	<b>∑</b> M 2□F	65 Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 12		Birthplace (State or Foreign Country) est Virginia				
	and w		Usual Residence of Decedent  10a. Slate 10b. County		10c. City, Town or Li	ocation				10d. Inside City Limits				
	Maryi f aho	to	Maryland Washin	gton	Нап	erstown				1 ☐ Yes 2 ☑ No				
	r 28a	Director	10e. Street and Number	gcon	IIag	10f. Zip Code		10	0g. Citizen of Wha	at Country?				
	death with the Maryland ms 23s or 28s-f show rmst be notified at		810 Beaver Creek	Road		217	40		USA					
036	d within 72 hours after death with the Marylan plene. r then "natural", or Items 23e or 28e-f ahow the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		American Indian, White, elc. white				
Š	72 hor	ted	15. Decedeni's E	ducation	16a. Dece	deni's Usual Occup	pation	7.7	16b. Kind of Busir	ness/Industry				
215-0036	within 72 ene. then "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)  _		during most of working	1						
7 0	filed w Hygiel other ti	S	8 17. Father's Name (First, Middle, Last,	0	neavy	equipmen	t operato		constru	iction				
<u>a</u>	o d a b	To Be	unknown				Mary Ba		naiden Sumame)					
Mary	shou and M amer	۲	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Rura		City or Town, Sta	ate, Zip Code)				
_	1 and 2 Heelth a sem 27 is		Carolyn Fiddler -	· wife	810	Beaver C	reek Rd.,	Hagerst	own, Mar	yland 21740				
saitimore,	S to I		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State		matory or other plac	ce)		20c. Location - Cit					
	t. Pag rtmen rtant: rjury		4 ☐ Donation 5 ☐ Other (Specif	(1)	Manor Ce		11/24			ton, Maryland				
g	permit. Pag Department important: I eny injury o		21. Signature of Funeral Service Licer	Mum			ess of Facility MIN Lson Blvd.							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Rectal	Concer				2 1/2 years				
	/Medical Examiner		resuming in dealing	Due lo (or as a	consequence of):									
		er	Sequentially list conditions, 1 dry, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	nonsequanna of):									
	cuted nd ransit	Examiner	that initiated events	c.										
Š	e exe sien ar urial-t		resulting in death) Last	Due to (or as a	consequence of):									
<b>68/6</b> 0,	icate be executed physicien and s the burial-transit	edicai		d										
X		/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, oulcome of	pregnancy				23d. Date of	al delivery				
C. Box	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	by Physician/M	in the past 12 months?  1  Yes 2  No 9  Unknown	1⊡Live birth 2 4⊡Pregnant at tii 9⊡Unknown	Fetal death 3	∃Ectopic pregnancy ∃ Other (specify) _	4		Month					
	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribu	le lo the cause of death?				
Hecords,	equire en sig ould b							1 ☐ Ye	s 2 10 3 (	Probably 4 Unknown				
သ	law rees because 2 sho	ompieted						24a. Was an		re autopsy lindings available or to completion of cause of				
-	The ste h page	Com						perform	ned? dea	Ih?  Yes 2 No				
VIII	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		104	26. Place of Death							
ō	Phys r this ral dir	2	1 Yes 2 No  27. Manner ol Death	1 U Inpatient	2 ER/Outpatier		4   Indising Hon		nce 6 Other (	(Specify)				
0	nding Ph tth. :: After thi e funerat	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Dale ol Injury (Month, Day )	Year) Injury	Wor	k? Yes 2 □No	.00. 00001100110	w injury cocurred					
DIVISION	r Atterned of the control of the con	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, str	reet, lactory, office	2	281. Location (Str. City or Town,	reet and Number (	or Rural Route Number,				
5	ital or irs aft rel Di	Cer												
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner slate	xamination and/or in	h occurred at the tir vestigation, in my o	me, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manni ite and place, and	er as stated. I due to the cause(s)				
	To ti To ti comp	ž	29b. Signature and title ol certifier			29c. Licens		1	d. Date signed (A	•				
1			Muchaer	1. Chulo	un MI	1 0	41667		11.2	3-00				
Śŀ	1-6		30. Name and address of person who	completed cause of dea		Print) Medic	41667 cl Cang	WI HE	sestin	n mo				
¥	Sta Registr	_	31. Date filed (Month Ov 26 2	32. Pigistrar		1 4.								
	riegisti			TO SEAR	Alla Alla	CORP CONTRACTOR								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#18perFH11/28/07, HWW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13:30 M 19/2007 ELLEN L. FOX 11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Stagnus hospital BALTIMORE "NONE" If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 ▼ F 75 578-36-0707 02/03/1932 WASHINGTON, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No MD BALTIMORE CATONSVILLE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 303 NORTH ROLLING ROAD 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) EEG TECHNOLOGIST VA HOSPITAL 18. Mother's Name *(First, Middle, Maiden Surname)* Margaret Jane McGurn 17. Father's Name (First, Middle, Last) Be CHARLES Y. LATIMER MARGARET JAN McGURN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE WEISBAUM DAUGHTER HOLMEHURST AVENUE, CATONSVILLE, MARYLAND 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition GARDEN OF REMEMBRANCE MEMORIAL PARK 11/21/2007 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State CLARKSBURG, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Linux 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYL AND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bilateral Preumon 24 days /Medical Due to (or as a consequence of): Examiner obstructive promonary 118012 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of)  $1 - v \chi$  ,  $e 1 e \eta$ Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) n signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown has been sig je 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? page neral Director: After this certificate filled in by the funeral director, pag Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after ö within 24 hours a Hospital 29a, Certifier ₹☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P22256 DI FETH BENRADUATE, MD 11/19/2007

State Registrar 31. Date filed (Month, Day, Year) NOV 2 1 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760 <u>Р</u> О Records, Freedman, Muriel or Vital

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica

31. Date filed (Month, Day, Year) NOV 2 1 2007 State Registrar

29a. Certifier

29b. Signature and tille

Medical



and manner stated.



29c. License number

00061302

29d. Date signed (Month, Day, Year)

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3:20 PM Aun 1= BORAH GERHOLD 22 2007 2/ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BARAMORE

| Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Hours | Min. | Mi Baltimore Univensity of Mangenno 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 T F Months 50 Maryland 213-68-6694 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 □Yes 🗶 No Marvland Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 10410 Sharpsburg Pike 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: white Specify 3 Widowed 4 Divorced Be Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WIIIIam R. Nave s 1 and 2 should be fill f Health and Mental H Item 27 Is marked oth other traumatic even Rosalie L. Reynolds Nave ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10824 Downsville Pike Apt. permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 22 Hagerstown MD 21740 Kevin L. Gerhold - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 28 2007 Smithsburg Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 aittin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) From Various bleeding Jastro In testmal **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in it ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 9 Cirnitosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2: autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1 res 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed attending physician and for use as the burial-trar Box 68760, signed by the a d be detached f Records, P.O. has certificate Division or Vital After this To the Hospital or Attending

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1

death. within 24 hours after deatt To the Funeral Director: completely filled in by the

05H-2

State Registrar

Medical

determined

4 Thomicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a Certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brunet R

NO United in of Manyens Menical Center 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:00 aM Sara O. Graham November 19 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖾 F **Director** 579-36-4510 80 January 22, 1927 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Firestone Drive 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: ģ Specify. White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Division Chief U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( 2 Roger Orrison Kathryn Tayman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Lockhart - Daughter 403 Firestone Drive, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/2007 Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 236. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Acute Onchronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-transit Thrombocytopenia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Coagulopathy attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 X No 1 ☐ Yes 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 🖾 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Registrar DHMH 17 Rev 1/2001

State

Medical

31. Date filed (Month, Day, Year) NOV 21 2007

29b. Signature and title of certifier

(Check only

Padma Chirumamilla, M.D., 7600 Carroll Avenue, Takoma Park, Maryland 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D6383

29d. Date signed (Month, Day, Year)

O

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Stanley Charles Hubbard, Sr. 2007 11:40P November 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehab. Center Walkersville Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 216-22-8585 81 4, 1926 Maryland Director Jan. Usual Residence of Deceden within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 X Yes 2 □ No rral", or items 23a or 28a-f sh Examiner must be notified Directo Frederick Maryland Woodsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Barrick Lane 21798 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1943-46 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event injury events. 12 draftsman/ designer construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be George W. Hubbard Myrtle I. Putman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Hubbard/ wife Woodsboro, MD 21798 Barrick Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Utica Cemetery 11/27/2007 | Utica, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home Jarine 404 S. Main St. Woodsboro, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 □Ectopic pregnancy Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No ork 24a. Was an has autopsy certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3∏ DOA this funeral ( 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signatur

and title of certifier

6

6 2007

0 DEC

ind address

Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

son\_who completed cause of death (Item 23a) (Type, Prir

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

REDEWICKMD 2170

**Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 3 iny or other traumatic event, the Medical Examiner must be not

permit. Pages
Department of
Important: If it
any injury or o

Baltimore, Maryland 21215-0036

Director

Funeral

þ

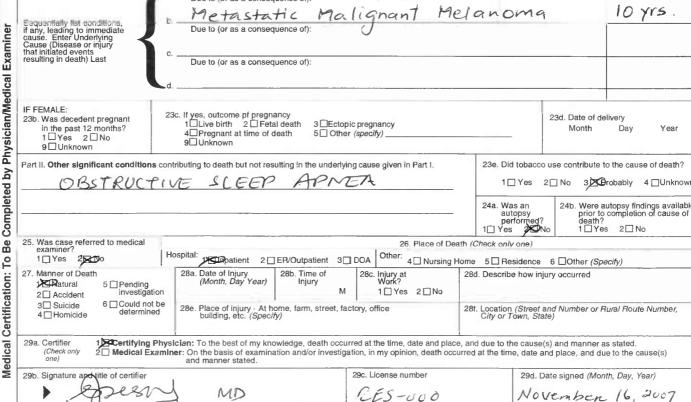
Completed

2

the Maryland

Physician/Medical ģ Be Completed ဥ

Registrar



DHMH 17 Rev 1/2001

State

THE JOHNS HOPKINS HOSPITAL GOONORTH WOLFE STREET BALTIMORE ND 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

College

PRIYANK DESAI

NOV 20

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/20 C. perFH 0874 12/6/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 20, 2007 **Physician** LEE VERNON KELLER 1:00F M /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. Cify, Town, or Location of Death Examiner Center Baltimore if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-12-1920 6. Sex 1 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. MARTINSBURG. WV 235-12-1546 87 Director Usual Residence of Decedent the Maryland 10c. Cify, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1 Yes XXNo Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ō 7401 SCHOOL AVENUE 21222 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (1) Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monee. PASTEURIZING DEPT. FOOD INDUSTRY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EARL KELLER GEORGIA McDONALD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY L. LACKL 7401 SCHOOL AVENUE DUNDALK, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place)
SMITHBURG CREMATORY 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State NOVEMBER Swithsburg, MD 4 □ Donation 5 □ Other (Specify) 25, 2007 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME 327 W. KING ST. PO BOX 821 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 HOUR Immediate Cause (Final disease or condition resulting in death) ELECTROMECHANICAL DISSOCIATION **Physician** /Medical Due to (or as a consequence of): **Examiner** HEMORRHAGE 1 HOUR equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed THORACIC ANEURYSM REPAIR HOURS Due to (or as a consequence of) as the burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Hinknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ABDOMINAL AORTIC ANEURYSM 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CORONARY ARTERY DISEASE autopsy performe HYPERTENSION 1∐ Yes 2 📉 No 25. Was case referred to medical examiner?
1 ★ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

Per Funeral Director: A setely filled in by the form 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11.20.07 D41749 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 7601 OSLER DRIVE, TOWSON. REICHMAN M.D. MARYLAND 21204

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 6 2007

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kathryn Skurner Kohler 4:30 PM November 23, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Washington County Washington County Hospital Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Director 160-20-6864 82 June 18 1925 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Maryland Washington Maugansville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U.S.A. 13914 Green Mountain Drive 21767 tems 23a Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ no If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 0 Baltimore, Maryland 21215-0036 Exam 1 ☐ Yes 2X No Specify White þ Specify: 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agency Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve once. John Skurner Katherine Skurner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13914 Green Mountain Drive Maugansville MD 21767 Walter E. Kohler - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 □ Cremation 3 □ Removal from State St. Joseph Cemetery Geistown Pennsylvania Nov 27 2007 4 Donation 5 Dother (Specify) permit. 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumon19 Immediate Cause (Final **Physician** reeks disease or condition resulting in death) /Medical ongestive heart failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Kidney disease Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 3 Probably 4 ☐Unknown 2 No Completed atrial Librillation 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of page 2: death? 1 ☐ Yes 2 No Yes Hospital or Attending Physician: Be 25. Was case referred to medic examiner? 26. Place of Death (Check only one) 2X No Other: 1 🔲 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Alatural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending after decral Director: An investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completely fi Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number D44996 Printappans Rd Boonsboro MD 21713 of death (Item 23a) (Type 05H-8 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 27 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of State of Registrar	-	epartment of Hone of Certificate of E			enje UU/ g. No.	39090
Physic		Decedent's Name (First, Middle, Last)				2. Date of Death Nov 17,		3. Time of Death
Physic /Medi	cal	James John Kavanagh	a hasi	4b. City, Town, or	Location of Death	Nov 1/,	4c. County of Deat	12:30ртм
Exami	ner	4a. Facility Name (If not institution, give street and nun Montgomery General Hosp		Olney	LOCATION OF DOGUN		Montgome	
Funeral Director		122-26-4717 1 <sup>™</sup> 2□ F	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb 19,	1934 New	hplace (State or Foreign yntYork
/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
e Mar	ctor	MD Montgomery	Silve	r Spring				1X Yes 2 □ No
with the a or 21	Dire	10e. Street and Number 3100 International Dr		10f. Zip Code 20908			g. Citizen of What Co United Sta	
paritimities, wai yiaing XIX 13-0000 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Medical Exercitational be notified at any injury or other traumatic event, the Medical Exercitation to other traumatic event, the Medical Exercitation to appear.	by Funeral Director	11. Marital Status 12. Was Dece	2 No 1933	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
72 hours	ted t	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupa	ution	ina 1	6b. Kind of Business	/Industry
within one.	Completed	Elementary/Secondary (0-12) College (1 5+	-4or 5+) Te	(Give kind of work done d life. DO NOT use retired, eacher	)		Education	
Hygie Other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M		
y idi	To B	John Kavanagh	QW.		Sara Co			
Midil d 2 sh d 2 sh th and 17 is m traum	P.	19a. Informant's Name/Helationship (Type, Filit)		. Mailing Address <i>(Street a</i> '120 Natelli				Zip Code)
S 1 and 1 Healt		Gilbert Simonetti/Broth	20b. Place of	Disposition (Name of y, crematory or other place	e) [	Date 2	0c. Location - City or	
Deficiency  Definite Pages Department of mportant: If it in injury or one		1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		ton National	l Jan	15,2008	Arlington	,VA
Dermit. Departimental		21. Signature of Funeral Syntics Licensee		22. Name and Addres				
		23a. Part1. Enter the disease, or complications that a shock, or heart failure. List only one cause on the shock of the sh	aused the death. Do r				Mashington est,	Approximate Interval Between
Physician								Onset and Death
/Medical Examiner		resulting in death)  Due to	(or as a consequence	arrosis	· Perro			
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	(or as a consequence	of):	cone			
ecuted and transil	Examiner	that initiated events c.	en HCS (or as a consequence	ot):				
ficate be executed physicien and sthe burial-transit		d ====	(or as a consequence	01).				
difficate	Aedical	U.						
the death certification of the attending ched for use es	hysiclan/M	in the past 12 months?	come of pregnancy pirth 2 ☐ Fetal death nant at time of death own	3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	Nivery Day Year
wrequires that the de been signed by the a should be deteched?	by P	Part II. Other significant conditions contributing to d	eath but not resulting in	n the underlying cause give	en in Part I.	23e. Did tob	il	o the cause of death?
nec he law e has b	Completed			-		24a. Was ar autops perform 1 \( \text{Yes} \)	prior to death?	utopsy findings available completion of cause of s 2 No
VICAL F rsician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 Do Hospital: 1	inpatient 2□ER/Ou	utpatient 3 DOA Othe	OF.	h Check only one	e) ince 6 □Other (Spe	acifu)
On Or VICA  Jing Physician:  After this certitic  tuneral director,	n: T		of Injury 28b.	Time of 28c. Injury		28d. Describe ho	- , ,	33,147
DIVISION  or Attending after death. Director: Afte	ertification:	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 □No	28f Location /St	reet and Number or F	Jural Boute Number
DIVISION OF VICE! et or Attending Physician: 7 s after death. In Director: After this certilicat et in by the tuneral director, ps	Sertif	determined 200. Flace	ing, etc. (Specity)	trm, street, factory, office		City or Town		and rioute realined,
Hospit 4 hour Funera ely tille	edical C	29a. Certifier (Check only one)  1 Aeritying Physician: To the bound one) and man	asis of examination ar	death occurred at the tind ad/or investigation, in my o	na date and clana pinion, death occur	and flue to the da red at the time, da	tuse(s) and manner a ate and place, and du	s stated e to the cause(s)
To the I within 2 To the I complet	Mec	29b. Signature and title of certifier	ner stated.	29c. License	a number	25	9d. Date signed (Mon	ith, Day, Year)
1		Ma fleu Mos	mfalls	T DO	05 941	14	11/18/2	7
		30. Name and ad less of person who completed during the state of the s	se of death (Item 23a)  O 1810 1	Prince +	Wilip	On O.	Circle 14	0
Regis	tate trar	NOV 2 1 2007	were &	Appell?	· · · · · · · · · · · · · · · · · · ·		<i>O</i>	

State

Registrar

DHMH 17 Rev 1/2001

Antit

32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

251

NOVEMBER 20 2007

07-00939	Please Type of Plint in Black indelible link. Linsuite All Copies Are i
Brandon Lambertson	State of Maryland / Department of Health and Mental Hygiene

2007 39092

			- For State Registrar				Certific	ate of	Death				F	Reg. No.	200	ן נ	0 0 0 0
	Physicia		<ol> <li>Decedent's Name (First, I</li> </ol>				·					2.	Date of Dea Month	ath Day	Year	3.	Time of Death
Medica	al Exami		BRANDON HOL										Month Novembe				1841 hrs
			4a. Facility Name (if not inst	-				41	o. City, To Salisbu		ocation of	Death			ounty of De comico	atn	
			Penninsula Regior					11			If Under	24110	P. Data of B			Rinthn	lace (State or
	Funeral		5. Social Security Number	6. Se			n yrs. last bii B	rtnday)	If Under Months	Days	Hours	Min.		/1976	I E or	oian	ry)Maryland
	Director	L	220-06-0233		M 2 F	-	)T	Yrs.					05/15			Couri	
	<u>s</u>	ŀ	Usual Residence of Decede 10a. State 10b. Co			110	c. City, Tow	n or Locatio	n -					-		10	od. Inside City Limits
	w any			ceste	r		ocomo									1	Yes 2 X No
	Aaryland 28a-f show 1 at once.	힕	10e. Street and Number						10f. Zip (	ode.				10g. Citizer	n of What C	ountr	P.
	ith the Maryland 23a or 28a-f sho notified at once.	Director	2018 Boston	5co9					218					US			
	th the 23a o		11. Marital Status	ROdu	12. Was De	andont Ev	or in II S	13 Was			anic Origi	in? (Spec	cify Yes or N			nerica	n Indian, Black,
	ath w	Funeral	1 Never Married 2	X Married	Armed	Forces?			s, specify						White, etc		
	er de		3 Widowed 4	Divorced	1 Yes If Yes, Give Y	2 _ <b>∑</b> ear	No	1	Yes 2	No	specify:			Sp	ecify: W	hit	:e
	urs af tural	by	15. Decedent's Education	Specify on	or Dates: ly highest gr	ade comple	ted) 16a	. Decedent	's Usual C	ccupatio	on (Give k			16b. Kin	d of Busine	ss/Ind	ustry
	72 hou	Completed	Elementary/Secondary (0	-12)	College	(1-4 or 5+)	_	during mo	st of work	ng life. I	DO NOT t	use retired	3)				
38	thin ne.	ם	12					Farme	er						icult	ure	<u> </u>
215-0036	ed wi		17. Father's Name (First, M							1			irst, Middle		ırname)		
2	be fil intal F irked rent,	Be	Marion Wayr			on							ye Bai				
2	should be filed with and Mental Hygiene 7 is marked other ti natic event, the Med	입	19a. Informant's Name/Rela				1						ral Route N				
MD 213	Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intit If Item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once		Susan Lamber 20a. Method of Disposition	tson/	wile		20h Place	2018 of Disposi					omoke Date		cation - City		
J.e.	s l a		1 Burial 2 Crer	ation 3	Removal	from State	crema	atory or oth	er place)		,,	11/1	2 /200				
Ĕ	Page ment tant: or ot	l	4 Donation 5 Oth	er Specify:			Rems	on Me									ty, MD
Baltimore,	pennit. Pages I and 2 should be fil De artment of Health and Mental H Important: If item 27 is marked injury or other traumatic event, i		21. Signature of Funeral Se	rvice Licen:	see				ame and			1101	loway				
			23a. Part I. Enter the disease	A COMO	lications that	caused the	death Do	10	)3 Li	nden	Ave	ardiac or r	ocomok respiratory a	rest, shock	or heart	2	Approximate Interval
	hysician Medical		failure. List only one of	ause on ea	ch line.		, 404(11, 20			_,,			,				Between Onset and Death
TY .	caminer		Immediate Cause (Final dis or condition resulting in de		Multiple In Due to (or as		ence of):									$\dashv$	
			Sequentially list conditions	b.													
		je l	if any, leading to immediate		Due to (or as	a consequ	ence of):										
		Examine	(Disease or injury that initial	red -	Due to (or as	a consequ	ence of):			- 53					_		
	uted d ansit	Ä	events resulting in death)	ası d.			•										
	ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED		AMENDE	)											
60.	ate be	Med	IF FEMALE:		23c. If yes	s, outcome	of pregnanc	у						23d.	Date of del	ivery	
687	ertific ding p		23b. Was decedent pregnat past 12 months?	t in the		e birth	a of dooth	- 1	tal death	3	Ectopic	c pregnan	су	N	<b>l</b> onth	Da	y Year
Box 68760.	atten atten for us	Physicia	1 Yes 2 No 9	Unknown		gnani at iii known	ne of death	5 Ot	her (Spec	ify)				- 1			
8	the do	Phy	Part II. Other significant of	onditions			ut not result	ing in the u	ınderlying	cause g	iven in Pa	art I.	23e. Did	tobacco us	se contribut	e to th	ne cause of death?
O.	s that gned leeta	by											1 🗆 ነ	res 2 🗸	No 3	Proba	bly 4 Unknown
8	equire een si ould b	ted											24a. Wa				ppsy findings available
jo	law r has b	Completed					<del></del>						pe	formed?	deat	th?	mpletion of cause of
Re	The ficate , page	ပ္ပြဲ								6 Place	of Dooth	(Check or	1 Ye	s 2 No	1 🗸	Yes	2 No
tal	ician; s certi rector	Be	25. Was case referred to n examiner?	Ī	Hospital:	Innationt	2 ✔ ER	/Outnatient			Other:		Home 5	Residen	ce 6 0	Other:	
<u> </u>	Phys rer thi	잍	1 Yes 2 N 27. Manner of Death	)	28a. Da			b. Time of I			ry at Work	·?	28d. Descrit				
2		io	1 Natural 5	Pending	Nov 1	nte of Injury onth, Day Yea 8, 2007	16	22 hrs		1 Y	res 2 🗸	No C	Oriver aut	o collisio	n		
Sici	Attend ar death rector: by the	icat	2 🗸 Accident	Investigati	28e P	lace of Injur	y - At home	, farm, stre	et, factory.	office b	uilding, et						al Route Number, City
Division of Vital Records. P.O.	tal or irs after irs Di	Certification:	3 Suicide 6 Homicide	Could not determine	be	fy) Loca						E	or Towr Boston Roa	i, State) ad & Redd	en Road,	Poco	moke City, MD
	To the Hospital or Attending Physician: The law requires that the death certificate bours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier	ng Physic	ian: To the t	pest of my k	nowledge,	death occur	red at the	time, da	ate and pla	ace, and o	due to the ca	ause(s) and	manner as	state	d.
	thin 2	Medical	one) 2 Medic	I Examine	r:On the bas	is of exami	nation and/o	r investiga	tion, in my	opinion	, death oc	curred at	the time, da	ite and plac	e, and due	to the	cause(s)
	F. 2 F. 8	₹	29b. Signature and title of	ertifier	3.73	, ototog.			290	. Licens	e number			29d. D	ate signed	(Mon	th, Day, Year)
			and	(						O.C.	M.E.			Nove	ember 19	9, 20	07
			30. Name and address of					a)				0:0-					
B	A5_		Ana Rubio MD.		nt Medica			1 Penn S	street, E	altimo	ore, MD	21201					
		tate		Year)	007	Régistrar's		do	whe								
	Regis	шы	140.7	~ 1 -													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - <sup>Day</sup> 2007 Month **Physician** 14, CALVIN JOHN LEE, Sr 0200 A M Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) Nov. 6, 1933 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Min. Maryland 1 **3** M 2 □ F 216-30-4298 74 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County Silver Spring 1 ☐ Yes 2 X No Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or be U.S.A. 20902 1505 Jasper Street "natural", or items 23a o Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 52-55 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Nat'l Oceanic I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mail Distributor Atmospheric Adm 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othe any injury or other traumatic event once. Be Mildred Lee Fenton Newman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)
1505 Jasper St, Silver Spring, MD 20902 19a. Informant's Name/Relationship (Type. Print) Carolyn Lee (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Norbeck Mem Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1∑ Burial 2 □ Cremation 3 □ Removal from State 11/20/07 Olney, MD 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral S 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Chronic Renal Failure /Medical Due to (or as a consequence of): Examiner Bronchiectasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed <u>Congestive Heart Failure</u> attending physician and for use as the burial-trar P.O. Box 68760 Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) signed by the aid be detached to 1 TVes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page this certificate 1∐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 11/14/07 D65305 30. Name and address of pers n who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

Nabila Khan, 31. Date filed (Month, Day, Year) NOV 2 1 2007



			1 - For State Registrar	State of	Maryland / Depa	artment of rtificate of		-	giene Rag. No. 007	39094
	Physici		1. Decedent's Name (First, Middle, La Kathryn Elizab		•			2. Date of De Month		3. Time of Death
-	/Medic Examir		4a. Facility Name (If not institution, giv Fahrney Keedy	e street and num	ber)		or Location of D	4c. County of Dea Washingt	1 3 70	
	Funeral Director		220-18-0831	ex □ M 2 1	'. Age (In yrs. last birthday) 87 Yrs.	if Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da August	9. Bir ay, Year) 9. Bir 17 1920	thplace (State or Foreign ountry) Maryland
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washir	gton	10c. City, Town or Lo	ocation onsboro				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with the	Funeral Director	10e. Street and Number 8507 Maplevill	e Road		10f. Zip Code	21713		10g. Citizen of What C	ountry?
036	72 hours after death with the Maryland natural', or items 23a or 28a-1 ehow dical Exantiner must be notitled at	þ	11. Marital Status  1 XNever Married 2  Married 3  Widowed 4  Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	ces? 2 <b>X</b> No	Was Decedent of If Yes, specify Cul	oan, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	I within 72 ho iene. r then "natur the Medical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4	(Give	dent's Usual Occu kind of work done DO NOT use retire Registere	during most of ed)		16b. Kind of Business Hospi	
/land	12 should be filed within h and Mental Hygiene. 7 le marked other then " fraumatic event, the Mes	To Be C	17. Father's Name (First, Middle, Last, J. Frank Long				1	Name (First, Middle	, Maiden Sumame) e Grossnick	le
	Pages 1 and nent of Healt int: if item 2: iry or other 1		19a. Informant's Name/Relationship (		ister 331	Sunbrook		agerstown	er, City or Town, State, Maryland 2	1742
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	/)	Smithsbu	natory or other pla rg Crema	tory 1	Date 1-26-07		g Maryland
Bal	permit. Departn imports any inju		21. Signature of Funeral Service Licer  23a. Part 1. Enter the disease, or com	Jason	v 1		ern Blv	d. N. Hage		yland 21742
	Physician /Medical	:	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. O	axiam C	and Lev	ing, such as car	ulac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	physicien and purial-transit sthe burral-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a consequence of):  The state of the st					74
Box 6	death certii e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 PANo 9 ☐ Unknown	1□Live bir	nt at time of death 5	Ectopic pregnand Other (specify)	ey .		23d. Date of de Month	livery Day Year
rds, P	The law requires that the ite has been signed by thi page 2 should be detache	by	Part II. Other significant conditions of	ontributing to dea	ath but not resulting in the u	nderlying cause gr	ven în Part I.		obacco use contribute t Yes 2□No 3□P	o the cause of death?
Vital Records,		Completed						24a. Was autor perfo	osy prior to death?	utopsy findings available completion of cause of
of Vita	Physician: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	Hospital: 1 ☐ Inp	patient 2 ER/Outpatien	it 3□ DOA Ot	har	Death (Check only only only only only only only only	one) dence 6 □Other (Spe	cify)
Division o	ding After fune	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Injury 28b. Time of Injury	Wo	iry at ork? ] Yes 2 □ No	28d. Describe I	how injury occurred	
Divi			3 Suicide 6 Could not be determined	286. Place o building	f Injury - At home, farm, str g, etc. (Specify)			City or To		
		Medical	29a. Certifier t☐ Certifying Ph (Check only one)	ysician: To the b iner: On the bas and manne	est of my knowledge, death is of examination and/or in or stated.	n occurred at the t vestigation, in my	ime, date and p opinion, death o	ace, and due to the occurred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licen	2 3 2 3		29d. Date signed (Moni	
hi	1.1		30. Name and address of person who	. 1			ر در د		11-26-11 wh Mt	1007
	Sta Registr		31. Date filed (Month Nov Year) 7	V	istrar's Signature	oride Co	ort. t	tagerstu	own Mi	) 31740

		1	State of Maryland / Depart State of Maryland / Depart Cert	rtment of Health and M ificate of Death		ene g. No. 007	39095
			Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physicia		Lacy Lloyd MC FARLIN		Month Nov.	Day Year 25 2007	7:30 <sup>a M</sup>
	/Medic Examin			4b. City, Town, or Location of Death		4c. County of Death	
	_Adriii.	•	Julia Manor Nursing Home	Hagerstown		Washingto	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Coun	ace (State or Foreign try)
	Director		411-38-4/83		Sept. 7	1926   Tenn	essee
	and w	-	Usual Residence of Decedent  10a. State 10b. County . 10c. City, Town or Loc	ation		11	Od. Inside City Limits
	l sho	ō		•			1 □Yes 2√∑No
	the N	Director	Maryland Washington Hagers  10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	try?
	with Ba or	0	532 Lynnhaven Drive #26	21742		USA	
	Jeath ms 2:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	city Yes or No-	14. Race - Americ Black, White,	
ယ	or ite	Fu	1 □ Never Married 2 N Married 1 1 1 Tryes 2 □ No	Yes 2 No Specify:	riloan, etc./	Casaibu	
8	72 hours after death with the Maryland natural; or items 23e or 28e-f show deal Evallation invalor molified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korean	Tes ZE NO Specily.		Wil	ite
21215-0036		Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of worki O NOT use retired)		16b. Kind of Business/Inc	lustry
12	within ene.	dm	Elementary/Secondary (0-12) College (1-4or 5+)			Aircraft N	/fα
	e filed within al Hygiene. I other than ' vent, the Me	ပိ	10 U I	nspector 18. Mother's Name	(First, Middle, M		11.5.
Maryland	ould be Mental arked o	To Be	Albert S. McFarlin	Minnie E	. McFarl	lin	
Z	s 1 and 2 should be I Heelth and Mental Item 27 is marked o other traumatic ev	-		Address (Street and Number or Rura	I Route Number,	City or Town, State, Zip	Code)
			Loretta M. McFarlin - Wife 532	Lynnehaven Road,			
Jre,			20a. Method of Disposition 20b. Place of Disposition cemetery, crem	ition (Name of atory or other place)	ate f	Oc. Location - City or To Davidson Co.	wn, State
Ē	Peges 1 and ment of Heelt ent: If item 2: ury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify) Harpeth H	ills Cemetery 11/		Nashville, 1	
Baltimore,	pernit. Page Department of Importent: If any injury or once.					Funeral Hor	
_	20 E 20		23a. Part1. Enter the disease, or complications that caused the death. Do not enter	15 E. Wilson Blvd			Z1/4U Approximate
	Priysician // // // // // // // // // // // // //	Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	1 2 1	work	Discorre	Interval Between Onset and Death
x 68760,	The law requires that the death certificate be executed the sabeen signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. Was decedent pregnant			23d. Date of delive	ary
O. Box	at the death by the atter stached for u	Physiclan/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
rds, P.	quires that n signed k uld be dett	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		pacco use contribute to t es 2 □ No 3 □ Prot	he cause of death?
Vital Records,		Completed			24a. Was a autops perform 1 Yes 2	med? prior to co	ppsy findings available impletion of cause of
Ita	certifica rector, p	Be (	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only on	Θ)	
of V	d is	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			ence 6 Other (Specia	5y)
ם	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe no	ow injury occurred	
sio	Attending in death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre		28f. Location (St	treet and Number or Run	al Route Number,
Division	- 9 - 6	Certification:	4 Homicide determined building, etc. (Specify)	set, lactory, office	City or Town	n, State)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifler (Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cared at the time, d	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,	
)			) Cres	05232	3	11-26-	2067
3	4-4		30. Name and address of person who completed cause of death (Item 23a) (Type, Farid Murshed 1126 Opal Court Hag				1
		ate	31. Date filed (Month (Pary Year)) 32. Registrar's Signature				
	Regist		mor 2 / 200/ Acc	rest of			

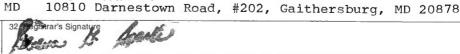
State Registrar

31. Date filed (Month, Day, Year) NOV 2 1 2007

Jimena Maria Gomez

30. Name and address of

person who comple



ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 0.0 7

			1 - For State Registrar	State of Ivi	arylanu /		tificate of		i wentai F	ıygıer Reg. f	F 0.	<i>)  </i>	39098
Г	Physici	ian	1. Decedent's Name (First, Middle, Las	•		_			2. Date of Month		Dav	Year	3. Time of Death
	/Medi		Frances	E.	Men	efce			Noven		18	2007	12:50 PM
	Examir		4a. Facility Name (If not institution, give				4b. City, Town,	or Location of De			4c. County		1
			Holy Cross Rehal	o und No	rainy (	cutor	Burton	soulle			Mon	tyom	wy
	Funeral		Social Security Number     6. S		e (In yrs. last I	birthday)	If Under 1 Year Months Days			Birth Day, Yea			lace (State or Foreign
	Director		577-07-3771	□M 2ဩF	98	Yrs.	Worthis	riours ivi	August			Virgi	
	p .		Usual Residence of Decedent  10a. State 10b. County		10- O't T								
	aryla sho	-	10a. State 10b. County		10c. City, To	own or Lo	cation					10	Od. Inside City Limits
	Ba-f	Director	Maryland Montgomery	7	Silve	er Spr	ing						1 Yes 2 No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. (	Citizen of V	Vhat Coun	try?
	8th w	- a	14735 Carona Drive				20	904	_	Un	ited S	tates	
	s filed within 72 hours after deeth with the Maryland I trygiene. other then "natural", or iteme 23a or 28a-f show vent, the Modical Exeminant be notified at	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? can, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-		e - America k, White, e	
20	or t	by Fi	1 Never Married 2 Married	1 ∐Yes 2 🕍 N If Yes, Give	10	1	☐Yes 2월No				Specify	,.	
2-003b	ural'		3 ☑ Widowed 4 □ Divorced	Year or Dates:							оросу	Wh	nite 
ဂ်	nat	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	16	Give (Give	ent's Usual Occu kind of work done	pation during most of и dd)	vorking	16b.	Kind of Bu	isiness/Ind	dustry
7	withir	E G	Elementary/Secondary (0-12)	Colfege (1-4or 5	i+)			9 <i>a)</i>			0	TT	
7	Hygie Ther Int, III	ပိ	11. 17. Father's Name (First, Middle, Last)				lomemaker	10 Mathada N	(5i Adid-	41- 64-1-4		Home	
yland	ntal l	Be		E1:4					ame (First, Midd			Θ)	
Ž	d Me d Me nark natic	5	•	Eliton				Mary		War			
20	12 sl h an 7 te r		19a. Informant's Name/Relationship (7	уре, Рппт)				t and Number or			or Town,	State, Zip	Code)
υ D	is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-7 show other traumatic event, the Medical Exemiter must be notified as		George Menefee, son  20a. Method of Disposition				Carona Dri		r Spring,		20904	A	
5	toff # Ite		1 🖾 Burial 2 □ Cremation 3 🖾	Removal from State	cernet	tery, crem	sition (Name of atory or other pla	ice)	Date	20c.	Location -	City or To	wn, State
	tant:		4 Donation 5 Other (Specify	2	Hill		Cemetery	,	23/2007		llsbor		
Dallimo	permit. Pages Department of It Important: If Ite ony injury or of		21. Signature of Fune al Service Licen	see h	*	118	Name and Addr 300 New Har	ess of Facility H	ines-Rina enue, Sil	ldi F ver S	uneral pring,	Home, MD 20	Inc. 0904
			23a. Part1. Epter the disease, comp	olications that caused	the death. Do	o not ente	er the mode of dy	ing, such as cardi	ac or respiratory	arrest,			Approximate
	Physician	X 16	Immediate Cause (Final	one cause on each m	10.							1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	crebro	1 U 4 5	i Nov	Accid	ent				One day
	Examiner			Due to (or as	a consequence	e ory.							
		e	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	b. Due to (or as a	i consequence	e of).						-	
	uted d ansit	듵	cause. Enter Underlying Cause (Disease or injury that initiated events										
,	exec n an ial-tr	Examiner	resulting in death) Last	Due to (or as a	consequence	e of):							
000	tificate be executed g physicien and as the burial-transit	cai		d									
0	ificat g phy as th	edicai		<u> </u>									Man (a)
5	ndin use	N/	fF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome	of pregnancy						23d. Date	e of deliver	rv
9	v requires that the death cer been signed by the ettendin should be detached for use	Physician/h	in the past 12 months? 1 ☐ Yes 2 ♠ No	1☐Live birth 4☐Pregnant at			Ectopic pregnanc Other (specify) _	y 			Mor		Day Year
į	by the	hys	9 Unknown	9□ Unknown									
_	s that	by P	Part II. Other significant conditions co	entributing to death bu	it not resulting	in the un	derlying cause gr	ven in Part I.	23e. Did	d tobacco	use contr	ibute to the	e cause of death?
3	pure n sig	D D	hypertens	2015					1 [	Yes	2 No	3 🗌 Proba	abfy 4 □Unknown
3	w rec	Completed							24a. W		245 14	Vara auto-	
	he la e has ige 2	Ē						<del></del>	aut	lopsy formed?	240. V	rior to com	osy findings available inpletion of cause of
5	in: T	ပိ	25. Was case referred to medical				_		1□ Yes			☐ Yes	2 No
>	ysictan: The law requir is certilicete has been si director, page 2 should	O B	examiner?	Hospitaf:	. A 🗆 ED/O		- Ot		eath Check only			-	
5	Phys r this ral di	-	27. Manner of Death	1 Inpatier		utpatient Time of	3□ DOA 28c. Inju	4 Nursing	Home 5 Re				)
5	ding h. Atte	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	Wo	rk?  Yes 2∐No	Est. Soscrib	5 110 <b>11</b> 111)	dry occurre	<b>5</b> 0	
9	deal deal ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home 1	farm stra			28f Location	(Street :	and Numbe	or Or Pural	Route Number.
	after Dire	Certification:	4 Homicide determined	building, etc	. (Specify)	, 5., 6	ot, ractory, cirios		City or T	own, Sta	te)	, or ribrar	riodie ridinosi,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.  To the Funeric Director: Alter this certificate has been signed by the ettending physicien and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit.	edicai C	(Check Only 2 Medical Exam	rsician: To the best of iner: On the basis of	examination a	ge, death	occurred at the ti	me date and place	ce, and due to the	e cause(	s) and mar	nner as sta	Illad the cause(s)
	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner state	ted.								
	5 ± ₹ 5		Λ.	14			29c. Licens	- number			ate signed		•
4	+			Mr.D.			VS	18461		No	Jembs	5,1	8,2007
	1		30. Name and address of person who c				A	Ο.		7. (			44 16 )
			31. Date filed (Month, Day, Year)	McD [	r's Signature	VINC	e puis	b Mr-	Svite .	504	010	rey,1	8, 2007 Maryland 70852.
	Sta Registra		NOV 2 1 20	1000	i a signature	Son	WE!						20852.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Robert Edward Nicholson November 17, 2007 1:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Spa Creek Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6. Sex 7 Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Hours 1 **X**M 2 □ F 73 126-26-0256 18, 1934 New York July Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Anne Arundel Arnold 1 ☐ Yes 2 🔀 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 Chautaugua Road 21012 U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1954–62 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: ≥ filed within 72 hours : Hygiene, 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ marked other than Elementary/Secondary (0-12) Pension Fund Administrator Plumbing & Pipe Fitting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Norman R. Nicholson Elsie I. Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane C. Nicholson/wife 101 Chautaugua Road Arnold, Maryland 21012 s 1 and 2 of Health a item 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H Important: If it any injury or o 1k Burial 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery 11/21/2007 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Fungral Service 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cucinon Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a detached f 9☐ Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tes 2 □ No 3 Probably Completed peen •24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

•24b. Were autopsy findings available prior to completion of cause of death?

•24b. Were autopsy findings available

•34b. Were autopsy findings available

•34b. Were autopsy findings available

•34b. Were autopsy findings available

•4b. Were autopsy findings available 24a. Was an certificate has 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Mer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State

Registrar

NOV 1 9 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Chopra

Aditya



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D57028

11-19-07

Annapolis, Maryland

		•	1- For State Of Maryland / State Registrar		tificate of		-	Reg. No.	2007	39100
AP.	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day	Year	3. Time of Death 5:00 pM
1	/Medic Examin	al	Raymond Alfred Owens  4a. Facility Name (It not institution, give street and number)		4b. City, Town,	or Location of Death	Novembe		County of Death	2:00 pm
À	Examin	er	Holy Cross Hospital			ver Sprin	g		Montgom	ery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)_ Yrs.	If Under 1 Year Months Days		8. Date of Birl (Month, Da	y, Year)	9. Birthp Cour	place (State or Foreign
L	Director		578-09-9486   88  Usual Residence of Decedent	113.			June 1	7,19	19 of	Columbia
	yland how at		10a. State 10b. County 10c. City, To	own or Loc	ation				1	0d. Inside City Limits
	Ba-f s	Director	Maryland Montgomery			lver Spri	ng	40- 011	en of What Cour	1 ☐ Yes 2 🙀 No
	with tage or 2		10e. Street and Number		10f. Zip Code	20904		rog. Citiz	U.S.A	
	death	Funeral	531 Randolph Road, #321–A  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. W		Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No	. 1	14. Race - Americ Black, White,	an Indian,
92	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ☐ No If Yes, Give		☐ Yes 2X No		o 1 110di 1, 010.)		Specify:	White
Maryland 21215-0036	tural"	ed by		6a. Decede	ent's Usual Occu	ıpation		16b. Kin	nd of Business/In	
215	hin 72 e. an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. Di	aind of work done ONOT use retire	e during most of wor ed)	king			
21	lygien lygien ner th		12	Ro	ute Sal	esman 18. Mother's Nam	no /First Middle		Lry & Ba	kery
ano	d be fi	) Be	17. Father's Name ( <i>First, Middle, Last</i> )  James Raymond Owens				get Elle		,	
ary	shoulind Me	L L		9b. Mailing	g Address (Stree	t and Number or Ru				Code)
	and 2 eaith a n 27 is									, MD 20904
Baltimore,	9 0 = =		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place ceme	of Disposi etery, crem	ition (Name of atory or other pla	ace)   11/	Date 23/2007		cation - City or To	
<u>=</u>	permit. Page Department Important: II any Injury o		4 □ Donation 5 □ Other (Specify) Gate  21. Signat⊌çe of Funeral Service Licensee		Ieaven C	emetery			ver Spr	ing, MD
Ra	permit. Departr Importa any Inje		Nancy A. Vecanti	Hi 11 م	nes-Rin .800 New	ess of Facility aldi Fune Hampshir	ral Home	e, In Silv	nc. ver Spri:	ng,MD 20904
Ā	2		23a. Part1. Enter the dispate, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dy	ring, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
ig.	Physician		Immediate Cause (Final disease or condition resulting in death)  A Massive Intro-		bral He	morrhage				Oliset and Death
G	/Medical Examiner		Due to (or as a consequence		ntia					
Ŋ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Coronary Art.		isease					
68760,	tificate be executed g physician and as the burial-transit	alE	bue to (of as a consequence	,c 01).						
89	= 0,0	ledical	0.							
ROX	ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal decent	ath 3□E	Ectopic pregnanc	су		2	3d. Date of delive	ery Day Year
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 5∐	Other (specify)_					
1	ires that signed by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the und	derlying cause gi	iven in Part I.	23e. Did to	obacco us	se contribute to t	he cause of death?
Sign	w require been sig should b	ted b					1 🗆 `	Yes 2∑	No 3 □ Prot	pably 4 □Unknown
Vital Hecords,	has be	Completed					24a. Was autop		24b. Were auto prior to co death?	psy findings available mpletion of cause of
e	(0 ==		25. Was case referred to medical			OC Diseaset Des	1□ Yes	2 XNo		2 No
	Physician: this certific ral director,	To Be	examiner?	Outpatient	3□ DOA Ot	26. Place of Dea ther: 4 ☐ Nursing H			☐Other (Special	(v)
n or			27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	b. Time of Injury		ury at ork?	28d. Describe l			
DIVISION	Attending F r death. ector: After by the funera	icati	2 Accident investigation 3 Suicide 6 Could not be	farm. stre		Yes 2 No	28f Location (	Street and	d Number or Run	al Route Number,
2	al or Atten s after death il Director: d in by the	Certification:	4 ☐ Homicide determined building, etc. (Specify)		,,,		City or To			
	e Hospital or 24 hours after e Funeral Dire	Medical (	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowled 2 ★ Medical Examiner: On the basis of examination and manner stated.							
	To the Hosp within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier		29c. Licen	ise number		29d. Date	e signed (Month,	Day, Year)
)	Q		My Alule		D	62520		Nove	ember 18	, 2007
	O		30. Name and address of person who completed cause of death (Item 23a			041		/ o 1	1000 has	10
	Sta	te	Maria D'Arbela, M.D., 1500 Fores 31. Date filed (Month, Day, Year) 32 Gegistrar's Signature	t Gle	n Koad,	Silver S	pring, I	naryl	Land 209	10
	Registr		31. Date filed (Month, Day, Year)  NOV 2 1 2007  32. egištrar's Signature	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TTM/7 perFH C874 12/6/07 NS State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 21 **Physician** HOWARD **PICARD** 04:30 PM 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death
BOUTIMOVE CI 4c. County of Death Examiner 5. Social Security Number f Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)

January 17, 1924 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign **Funeral** 079-18-1324 New York Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Virginia Arlington Arlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4651 N. 25th Street 22207 "natural", or Items 23a USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Catholic Priest Clergy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Yonkers Arthur Picard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph Giordano (Friend) 4651 N. 25th Street, Arlington, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. John Cemetery Queen, N.Y. 4 Donation 5 Dother (Specify) 11/30/07 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Home Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA 22203 23a. 211. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days **Physician** /Medical heart disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner arcuter than insufficiency and attending physician a for use as the buriat-Division or Vital Records, P.O. Box 687607 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 TYes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: \( \) completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19516 November 21, 2007 sinai Hospital of Baltimore 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16, 2007 **Physician** November 3:05 P M Allan Marshall Pitts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Oct | 20, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 1 XM 2 □ F New York 48 219-72-1355 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Tyes 2 TXNo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 9014 Bradford Road 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 XNever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Manager marked other alth and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon Marshall Pitts Marguerite Elaine Wheaton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an important: If Item 27 is any Injury or other trauonce. David Andrew Pitts/brother 6142 Freedom Ave. Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 11/20/07 Beltsville, MD 21. Signature of Funeral Going Home Cremation Service P.O. Box 784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final Cancer of the Rectum **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 Yes 2 No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? Yes 22 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other:  $_{4\square \, Nursing \, Home}$  5  $\square \, Residence$  6  $X \, Other \, (Specify)$  hospice 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospitai

Box 68760.

Ö

Division or Vital Records, P.

DHMH 17 Rev 1/2001

29a, Certifier

29b. Signature and litle of certifier

31. Date filed (Month, Day,

ang

Year)

Medical

State

Registrar

m6

Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

and manner stated:

32. gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D64615

29c. License number

29d. Date signed (Month, Day, Year)

November 17, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 12:15P 19, Edith Kellogg Jones Picken Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X 84 Director 578 28 4465 Aug. 19, 1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 TypYes 2 □ No Gaithersburg 10f. Zip Code Director MD 10g. Citizen of What Country? 10e. Street and Number with United States

14. Race - American Ind
Black, White, etc. 211 Russell Ave.,#51 20877 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1⊡Yes 2X∑No Saltimore, Maryland 21215-0036 Specify Specify: White 9 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home Ith and Mental Hygier 27 is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Edmund Lyddane Jones, Sr. Bettina Prescott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important: If item 27 is any injury or other trau Edith D. Picken/Daughter 2018 Rockwell Ave. Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/07 Rockville, MD Rockville Cemetery 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funer Washington, DC 20016 5130 Wisconsin Ave., NW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Hypoxemia Sequentially list conditions, if any, leading to immediate cause. End Unerly g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Shock anding physician and use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 X No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 45 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2🔽 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOO65478 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 9901 Medical Center Drive Ardekani Sanaer Rockville, MD egistrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 1 2007 Registrar

DHMH 17 Rev 1/2001

Registrar

NOV 2 1 2007

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Schature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Year ENRIETTA YNOLDS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA PARK If Under 24 Hrs. SEVERNA ISE RD SENESIS Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** 035-32-8602 Days Hours Months Min. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No SEVERNA MD Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? JE RD or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Marned Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩Widowed 4 Divorced DHITE "neture!" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATOR INIVERSIT permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other.
eny injury or other traumes? other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, McCullock HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 293 TOLSTOY LANE SEVERNA PARKMO. 21) 46 Thurman REYNOLDS, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State -24-07 HANCVER FROENT CREMATORY 4 □ Donation 5 □ Other (Specify) mature of Funeral Service Licensee 22. Name and Address of Facility

Daugherty Family Funeral Home And Cremation Center, P.A. Part1. Enter the disease, or com shock, or heart failure. List only 2601 Mountain Road - Pasadena, MD, 21122 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hours **Physician** umor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 10 Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Donknown 1 🗌 Yes 2 🗆 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 🗌 Yes 20 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Playe of Death (Check only one) Hospital: Other: 201X0 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 3□ DOA Certification: To 27. Manne i Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral C 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signa up and title of perifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

6

State

who completed cause of death (item 23a) (Type te.

31. Date filed (Month, Day, Year)

6 2007

. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JR 1458 Harold 11 13 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical Center Anne Arundel Anne Arundel Annapolis 8. Date of Birth (Month, Day, Jan 22 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** †**∑**M 2□ F Jan 74 Yrs. 577-44-3311 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at tyETYes 2 ☐ No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or ? r must be r USA 21403 3444 Newport Ave Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify. þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than 12th 3vrs Chemist Department of Health and Mental Hygie Important: If Item 27 is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold C. Smith Helen Hyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tomilynn Smith(Daughter 3444 Newbort Ave Annapolis, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial | 11-19-07 4 □ Donation 5 □ Other (Specify) Suitland, Md. 21. Signature of Funeral Service Licensee Winname Redere of Eacil Bons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 1004 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician vers) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1119 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performe death? 2□ No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA ၉ 1 Yes 27. Manner of Death 1 Natural 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? (Month, Day Year) 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIMARZIO MD. 2003 Medical Porhway suite 100 LISa 7. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 2007 Registrar

	For State Registra
in al	1. Decedent's Gertru
er	4a. Facility Na Dove F
	5. Social Secu 215-42 Usual Reside
ctor	10a. State Maryla
ral Dire	10e. Street an
Funera	11. Maritai St

**Physiciar** 

/Medica

Examine

**Funeral** 

Director

28a-f show

ö

Certificate of Death Reg. No. Name (First, Middle, Last) 2. Date of Death Day Month 11 ude Elaine Sprinkle 18 2007 4c. County of Death 4b. City, Town, or Location of Death ime (If not institution, give street and number) Westminster Carroll louse if Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay, Year 2/17/1943 rity Number 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔀 F 64 2-0265 nce of Decedent 10c. City, Town or Location 10b. County Upperco Baltimore 10g. Citizen of What Country? 10f. Zip Code Carrollton Road 21155 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Shaffer Hilda A. Nash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walter Jacob Sprinkle - Husband 4004 Carrollton Road Upperco Maryland 21155 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Lutheran Cem. 11/21/2007 20c. Location - City or Town, State 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 ☐ Removal from State Upperco Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fuperal Service Licen Eline Funeral home 934 south main street Hampstead Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary embolism Due to (or as a consequence of): disease or condition resulting in death) Metastatic breast cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify)

To the Hospital or Attending Phwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral v

þ

Completed

Be ၉

Certification:

Medical

State

Registrar

29a, Certifier

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? □Yes 2□ No

November 19, 2007

3. Time of Death

5:40 A.

10d. Inside City Limits

Approximate Interval Between Onset and Death

sev. years

Year

(Specify) Dove house

2 weeks

1 ☐Yes 2☐No

Birthplace (State or Foreign Country)

Maryland

White

Year

			12 100 25 10 10 10 10 10 10 10 10 10 10 10 10 10			
25. Was case referred to medical		26. Place of De	ath (Check only one)			
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 X Other (Specify) Dove h			
27. Manner of Death 1X Naturai 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred			
3 Suicide 6 Could not t 4 Homicide determined		, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)			

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Physician Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D-0022517

30. Name and address of person wh completed cause of death (Item 23a) (Type, Print)

1005 South Main Street Hampstead, Maryland 21074 Stephen Laiken M. D.

31. Date filed (Month, Day, Year) NOV 20 2007

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours a

To the Funeral C

completely filled

Registrar DHMH 17 Rev 1/2001

State

Bannen

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

MP

29c. License number

MOO 60335

327

November 17, 2007

20832

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland	-	artment rtificate			and M	lental Hy	_	0007	20110
		· ·	Registrar  1. Decedent's Name (First, Middle, La.	st)		Cei	incate	9 01 1	Dealli		2. Date of De	Reg. No	2001	3, Time of Death
	Physici		Senono Shields							ļ	Month	Da		
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, T	Town, or	r Location o		мочешре		2007 County of Death	12:05A
	E Admini		2020 Forest Dale	Drive			SI1v	er S	Spring	2		Mo	ntgomer	7
4.5%	Funeral		Social Security Number     6. S		e (In yrs. l	ast birthday)	If Under 1				8. Date of Bi (Month, Da	rth		place (State or Foreign intry)
 	Director		137-09-1997	□M 2 <b>⊠</b> F	91	Yrs.							916 New	
	and www.		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation	_						10d. Inside City Limits
	Maryl f sho	ō	Maryland Montgome	ry	Silv	ver Sp	ring							1 XYes 2 No
	r 28a	Director	10e. Street and Number		<u>.                                    </u>		10f. Zip (	Code			T	10g. Cit	izen of What Cou	intry?
	h with		2020 Forest Dale	Drive			2090	03			-	Unit	ed State	20
	ems ser my	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	S. 13.		ent of H	ispanic Orig	gin? (Spe	cify Yes or N		14. Race - Amer Black, White	ican Indian,
9	or its		1 Never Married 2 Married	1 ☐ Yes 2 1	10		1 □ Yes 2	_	Specify:	, 1 40110	indan, c.c.,		SpecifyWhit	
ë	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:								100		
5	n 72 i "nat ledica	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual kind of work DO NOT use	k done d e retired	ation during most d)	t of worki	ng	160. K	ind of Business/I	naustry
12	withi iene. than the M	m o	Elementary/Secondary (0-12)	College (1-4or 5	+)		ege Ad					E 4	ucation	
D		Be C	17. Father's Name (First, Middle, Last,				ege_A				(First, Middle			
<u>lar</u>	ould be Mental larked o	To B	William Henry Fra	nklin					Senon	ıo An	toinet	te H	o1mes	
Baltimore, Maryland 21215-0036	id 2 should be tth and Mental 27 is marked of traumatic ev	·	19a. Informant's Name/Relationship (	Type. Print)		1							or Town, State, Z	
Σ.	ss 1 and 2 of Health item 27		Elizabeth Phillips	s- daughte	<u>r.                                    </u>								ring, MI	
ore e	of h		20a. Method of Disposition  1 Burial 2 Coremation 3	Removal from State	20b. Pl	ace of Dispo emetery, crer	sition (Nam natory or oti	ne of ther plac	ce) 1	1-21	ate -2007	20c. Lo	ocation - City or T	own, State
	permit. Pag Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specif	y)	For	t Lin	coln (	Crem	atory	•		Bre	ntwood,	MD
E E	permit. Departr Importa any inj		21. Signature of Tuneral Service User	is e		1.0	O A O D	a Adare:	ss of Facility	y Sim	ple Tr	ibut	e	0.50
-			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death	. Do not ent	er the mode	of dvin	TITE	cardiac o	r respiratory a	VIII	e, MD 20	Approximate
	Dhusisian	0 11	shock, or heart failure. List only Immediate Cause (Final										1	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Chronic Due to (or as			ve Pul	Lmon	ary D	isea	se			years
	Examiner													
	D =	ner	Sequentially list conditions,	Due to (or as	a conse 🚚	ence of								
	ecuter ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C										
ŠĆ,	ate be executed hysician and the burial-transit		resulting in death, East	Due to (or as	a consequ	ence of):								
09/80	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		d					-					
X S	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome	pf pregna	ncy							23d. Date of deli	100/
X R R	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1⊡Live birth 4⊡Pregnant at	2 🗆 Fetal	death 3	Ectopic pre Other (spe	egnancy ecify)	<u>'</u>				Month	Day Year
oj.	t the c by the achec	hysi	9 Unknown	9□Unknown										
ις. J	res that the de signed by the a be detached t	by P	Part II. Other significant conditions of	ontributing to death bu	ıt not resu	Iting in the ur	nderlying ca	use giv	en in Part I.		23e. Did	tobacco i	use contribute to	the cause of death?
ğ	w require been siç should b	edt	Dementia								1 🗆	Yes 2	TXNo 3 □ Pro	bably 4 Unknown
ပ္ပ	~ O =	Completed	Depression								24a. Was	an	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	. 12 0	Com									perf 1∐ Yes	ormed? 2 ₽ No	death?	2 □ No
Vital Records,	nysician: The law lis certificate has I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Louis		of Death	(Check only	one)	207	
ō	ding Phys h. After this funeral dir	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 ☐ Inpatie		ER/Outpatien 28b. Time of			4 🗆 INU		ne 5 Res 28d. Describe		6 ☐Other (Spec	ify)
0	ding h. After fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	M Z	3c. Injur Worl 1 □	k? Yes 2∐1		edd, Describe	now mju	y occurred	
UIVISION	Attending Physician: If death. ector: After this certific by the funeral director,	fica	3 Suicide 6 Could not be	28e. Place of inju	ry - At ho	me, farm, str	eet, factory,							ral Route Number,
-	5 분 분 드	Certification:	4 ☐ Homicide determined	building, etc	:. (Ѕреслу	)				ļ	City or To	wn, State	)	
		cal	29a, Certifier  (Check only 2 Medical Exam	ysician: To the best on niner: On the basis of	of my know	vledge, death	n occurred a	at the tir	ne, date an	d place,	and due to the	cause(s	and manner as	stated.
	# 는 # 등	ledical	one)	and manner sta	ted.						ed at the time			
	Non To	Σ	29b. Signature and title of certifier	. (-	0.0	. ,	29c.	License	e number			29d. Da	te signed (Month	, Day, Year)
	4		" Illeen Kei	sen-co	ce	1 M		3159	9			Nove	mber 19	2007
			30. Name and address of person who Rith Keven-Cohen				,	<b>.</b>	1	<b>.</b> .		00-		
	Sta	te	Ruth Keven-Cohen, 31. Date filed (Month, Day, Year)	32 Registra	Geor ar's Signat	ure		51.	Lver S	sprii	ng, MD	2091	0	
	Registr	ar	NOV 2 1 20	07	A	e the	and B							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's, Name (First, Middle, Last) 2. Date of Death Physician 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner shaely Home Crove Nursing ock Montgomer 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Vearl Days Hours Months 1□M 2√F 579-32-2754 96 Director Nov 10,1911 England Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show ral", or items 23a or 28a-f show Examiner must be notifled at MD Montgomery Chevy Chase 1 X Yes 2 □ No Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 1 and 10 the traumatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be n 5480 Wisconsin Ave 20815 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary International OAS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank K. Scott Mabel Harris ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Scott / Nehpew 800 Madison St., Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of H Important: If its any injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State National Crematory 11-20-07 Falls Church, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Joseph Gawler's sons, INC 21. Signature of Fun Service Licenses 5130 Wisconsin Ave, N.W. Washington DC 20016 e, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final Maluntrition Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last de a eva evidua que offi-Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760, attending p ast IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy
performed?

1 Yes 2 No has le 2 er this certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 6 Norsing Home 5 Residence 6 Other (Specify) SINO 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending within 24 hours after con-To the Funeral Director After aniately filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10

State Registrar

31. Date filed (Month, Day, Year) 32. Pigistrar's NOV 21 2007

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



221

Shady

trove Rd. E208, ROCKVILLE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** NOVEMBER В. SCHNEIDER 2007 18. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🖾 F 100 Yrs. 11/05/1907 NEW YORK Director 153-30-1808 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Directo MARYLAND MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 WHIPPOORWILL COURT 20852 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐No ⋧ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME s 1 and 2 should be filed w f Health and Mental Hygier Item 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH BRAGER CELIA TEITS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 WHIPPOORWILL COURT, ROCKVILLE, MARYLAND JANET S. LEVINE, DAUGHTER 20852 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 対 Burial 2 ☐ Cremation 3x Removal from State EASTON CEMETERY 11/21/2007 EASTON, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 in 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. RUPTURED AORTIC ANEURISM /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ś 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Vital 1□ Yes 2 ₹No Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To 0 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: filled n by the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only one) 1 ocrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D26259 11/19/2007 30. Name and address of person who complete Lause of death (Item 23a) (Type, Print) AVA A. KAUFMAN, MD 8218 WISCONSIN AVENUE, BETHESDA, MARYLAND 20817 31. Date filed (Month, Day, Year) State 21 NOV 2007 Registrar

DHMH 17 Rev 1/2001

of to

<

Ö

SCA

68760,

Box

۵.

Record

Physicia /Medic Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burla-transit Division or Vital Records, P.O. Box 68760,

Physician /Medical	IOHN FINARII THOMAS SK									7 8:54 AM	
Examiner Funeral Director	5	ia. Facility Name (If not institution, give  1.5 FA Hed)  6. Social Security Number  6. Security Number  219–36–8075	al CentER	last birthda Yrs.	y) If Under 1 Year	r Location of Death	8. Date of Bird MAY 5,	h (	AAC 9. Birt		
alth and Mental Hygiene.  n 27 is marked other than "natural", or items 23a or 28a-f show ner traumatic event, the Medical Examiner must be notified at  To Be Completed by Funeral Director	$\vdash$	Usual Residence of Decedent 10a. State 10b. County  MD CHARLES		y, Town or HESVI						10d. Inside City Limits 1 X Yes 2 □ No	
r items 23a or 28a-f sk liner must be notified Funeral Director		10e. Street and Number 6551 WIMBUSH DRIV			10f. Zip Code 20637			10g. Citizen of What Country? UNITED STATES			
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	+	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:	.S. 1	3. Was Decedent of H If Yes, specify Cub  1  Yes 2 No	an, Mexican, Puert	pecify Yes or No o Rican, etc.)	ify Yes or No- lican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: BLACK			
ygiene. ner than "natur: nt, the Medical E	-	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Gi life	cedent's Usual Occupive kind of work done  b. DO NOT use retire  ABORER	oation during most of wor d)	rking	16b. Kind of Business/Industry CONSTRUCTION			
Mental Hyg arked othe atic event, To Be C	1	17. Father's Name (First, Middle, Last)  JAMES EDWARD THOM	AS			18. Mother's Nan FRANCES				THOMAS	
m 27 is ma her trauma		19a. Informant's Name/Relationship (7 HELEN THOMAS/WIFE		6551	1 WIMBUSH		,01125 ( 2 ,			D 20637	
trant of H tant: If Iter jury or oth		20a. Method of Disposition  1	Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MARY'S CHURCH  Date 20c. Location - C BRYANTO						MARYLAND	
Uepan Import any Inj once,		21. Signature of Funeral Service Licen LYDIA C. THORN	TON JOHNSON		IHORNTON F 3439 LIVIN	UNERAL HO	OME, P.A AD, INDI	AN HE	AD, MI	20640	
attending physician and rouse as the burial-transit auginal rouse as the burial-transit cian/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	unosi	lage	2						
Si ed		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of constitutions of the second point of the sec	al death	3□Ectopic pregnanc 5□ Other (specify) _	у		23	d. Date of de Month	livery Day Year	
been signed by the should be detach		Part II. Other significant conditions of	ontributing to death but not res	sulting in the	1) 0/-	ven in Part I.	23e. Did t			o the cause of death?	
ertificate has been signe ector, page 2 should be o Be Completed by		Hyperfernic itistroy of 25. Was case referred to medical	r Cancer Pro	stad	ع	26. Place of Dea	24a. Was auto perfo	psy ormed? 2 \( \text{No} \)	24b. Were a prior to death? 1 □ Yes	utopsy findings available completion of cause of 2 No	
this ce al direc		examiner? 1 💢 Yes 2 ☐ No		] ER/Outpa		4 LI Nursing F	lome 5 ☐ Resi	dence 6	□Other (Spe	ecify)	
within 24 bours are found and within 24 bours are found and completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl		27. Manner of Death  1  Natural  2  Accident  3  Suicide  4 Homicide  5  Pending investigation  6  Could not be determined		28b. Tim- Injur ome, farm, fy)	ry Wo M 1□	ryat rk? ]Yes 2∐No	28d. Describe  28f. Location ( City or To	Street and		ural Route Number,	
ithin 24 hours the Funeral ompletely filled Medical Co	-		ysician: To the best of my kno niner: On the basis of examina and manner stated.								
vithir To th comp		29b. Signature and title of conflict	L-		29c. Licens	4/019		11/	20/0	th, Day, Year)	
D Z State		30. Name and address of Sein, 131. Date filed (Month, Day, Year)	ompleted cause of death (Iter  3460 C  32. Rigistrar's Sign	10 W	Pe, Print)  Ashmy to	load,	Quite o	203 A	1 WH	doef, MP200	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ам yaia November 14, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Year) 1 □ M 2 🛛 F Director 041-14-6118 March 20, 1915 Vermont Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2X No Funeral Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 824 C South Leisure World Blvd. 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. I ☐ Yes 2 ☑ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Caucasian If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon Hair dresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B မ Anton Hardson <u>Pauline Sankowski</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia L. Goolkasian / Daughter 3810 Glen Eagle Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/20/2007 | Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Furieral Service Licenses 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebrovascular /Medical Due to (or as a consequence of): Examiner Possible Myacardial Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed pertensive physician and s the burial-tran Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowh Month 5 Other (specify) ed by the a signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy perform 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: Certification: To 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Olney 2083 INA

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 2 1 2007

18101

Prince Philip Drive

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland Registrar	d / Depa		lealth and M	lental Hygi	_	39115
	Physici		. Decedent's Name (First, Middle, Last) MARGARET LOUISE HANCOCK UL	RICH			2. Date of Death Month		3. Time of Death
9	/Medio Examin		a. Facility Name (If not institution, give street and number)  Manokin Manor Nursing Home			r Location of Death		4c. County of Dea	th
	Funeral Director		. Social Security Number 6. Sex 7. Age (In yrs. la 1		If Under 1 Year Months Days		8. Date of Birth (Month, Day, 10/3/19	9. Bir (Co. 2) 9. Bir	thplace (State or Foreign ountry)
	aryland show	<b>.</b>		, Town or Lo					10d. Inside City Limits
	ith the Ma or 28a-f	Directo	0e. Street and Number	omoke	10f. Zip Code	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10	g. Citizen of What Co	1 ☐ Yes 2 No
	r death w	Ineral	4743 Fleming Road  1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. 13. V	21851 Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - Ame Black, Whit	
9003	hours afte urel', or li	d by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 No If Yes, Give Year or Dates:	1	∏Yes 2∏XNo	Specify:		Specify: W	hite
1215-	within 72 ane.	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give I	lent's Usual Occup kind of work done DO NOT use retired Iresser	ation during most of works d)	ng	6b. Kind of Business Beauty	Andustry
and 2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Iteme 23s or 28s-f show sumatic event, the Medical Exandral marker must be rediffed at	To Be Co	12 7. Father's Name (First, Middle, Last) Edward Hancock	- Indirect	ir cobcr	18. Mother's Name		aiden Sumame)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "naturel", or Iteme 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be notified at one.		19a. Informant's Name/Relationship (Type, Print)			and Number or Rura	il Route Number,	City or Town, State,	
nore,	ages 1 and of Heali Hitem 2 or other		0a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ Removal from State	ace of Dispos metery, crem	sition (Name of natory or other place	ce)	Date 2	0c. Location - City or	Town, State
Baltin	bermit. Pa Departmen Mportant Iny injury		4 Donation 5 Other (Specify) More	22	Mem. Parl	ss of Facility Hol	loway Fu	arkville, neral Home	e, P.A.
100	*		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	3 Linden of dying the mode of dying	Ave. Poor	comoke C	ity, MD 2°	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a	ence of):	DEMEN	ITTA			10 years.
		iner	Sequentially list conditions, any, led fing to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events c.	ence of):					
760,	ate be executed hysicien and the burial-transit	cai Examiner	hat initiated events c.  Due to (or as a consequence consequence)	ence of):					
99	leath certificate attending physi d for use as the l		F FEMALE: 23c. If yes, outcome of pregnan						
O. Box	the hee	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome or pregnant at time of deceded in the pregnant at time	death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	livery Day Year
99 n	v requires that the death been signed by the atte should be detached for	Ď	art II. Other significant conditions contributing to death but not resul	ting in the un	nderlying cause giv	en in Part I.			o the cause of death?
) Q (	has b	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
₹%! Z\2	fing Physicien: Th. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?		To:	26. Place of Death		<sup>™</sup> No 1 □ Yes	s 2□ No
10.5 10.5 10.6	eath. or: After this o	lon: To	7. Manner of Death 28a. Date of Injury (Month, Day Year) 1. ✓ Natural 5 □ Pending	R/Outpatient 28b. Time of Injury	28c. Injun Wor	y at k?	ne 5 Residen 28d. Describe hov	nce 6 □Other (Spe v injury occurred	cify)
3. Sivision	or Attendent free death frector: n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre		Yes 2 □No	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
24	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medicai Ce	29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination	ledge, death	occurred at the tin	ne, date and place, a pinion, death occurre	and due to the cau	use(s) and manner as te and place, and due	s stated. e to the cause(s)
•	To the within 2 To the comple	Med	19b. Signature and title of certifier		29c. License	e number	290	d. Date signed (Mont	th, Day, Year)
	BA5		0. Name and address of person who completed cause of death (Item :		Print)	1359	1	November	2015 2007
	Sta Registr		14 15 . 5 . DIV/S/ON ST , S4-1313 ( 11. Date filed (Month, Day, Year) 32 . negistrar's Signatu  NOV 2 1 2007	,		04			
***	ricgisti	al	MAN O I CAMI DERING TO	M					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of M	arylan	•		t of H		and M	-	giene Rag. No.	' U U 7	39116
_	/sicia		1. Decedent's Name (First, Middle, Las								2. Date of De Month	ath Day	Year 2009	3. Time of Death
	ledic amin		Mary Katherine 4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death	1 - 5 4	4c.	County of Dea	
Fune	aral		Holy Cross Rehab  5. Social Security Number 6. Se			nter last birthday)		1 Year	Irton:	24 Hrs.	8. Date of Bir	th Year	Montgo 9. Bin	thplace (State or Foreign
Direc	_		496-56-7410	⊐м 2 <b>∏</b> F	94	Yrs.	Months	Days	Hours	Min.	(Month, Da Jan. 1			(Ilinois
and	4	-	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
Mary F-f eho	Ded	ţō	Maryland Montgo	omery		Kens	inat	~~						1 ☐ Yes 2 🕏 No
ith the	to e	Oirec	10e. Street and Number			ACHS	10f. Zij	Code					zen of What Co	ountry?
ath w	TANK T	Funeral Director	9602 Dewmar Lane	12. Was Decedent	Ever in 11	6 12 1	Nac Dass	2089		igin? (Spe	city Ves or No		SA 14. Race - Ame	arican Indian
ite; Mal ylalla Z I Z I D-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mentel Hygiene. Item 27 Is marked other than "natural", or itema 23a or 28a-f show	Jack I		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces' 1 ☐ Yes 2 🖎	?		_				cify Yes or No Rican, etc.)		Black, Whit	te, etc.
ours a	EXA	d b	3 <b>X</b> Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes		Specify:				Specify: Whi	
in 72 h	edica	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		16a. Deced (Give life. L	kind of wo	al Occupa ork done d se retired)	luring mos	t of worki	ng	16b. Kii	nd of Business	/Industry
d with	De N	mo	Elementary/Secondary (0-12)	College (1-4or	5+)		Homer	naker	•				Own Ho	ome
Laryland 6 12 Should be filed within and Mentel Hygiene.	Vent.	Be	17. Father's Name (First, Middle, Last)								(First, Middle			
should Ind Men	netic	ဍ	Joseph Yavornik  19a. Informant's Name/Relationship (7	ivos Print)		19b Mailin	a Addres	/Stront a			Obran		n r Town, State,	Zin Code)
ING 1d 2 sl lith an 27 le r	ne.		Mary Lee Helmsen								ington			Lip 0000)
permit. Pages 1 and 2 Depertment of Health a Important: If item 27 is	othe		20a. Method of Disposition  1 Burial 2 Cremation 3 D			Place of Dispo	sition (Na	me of			20,		ocation - City or	Town, State
Definition Pages Dependent of mportant: If if	nry o		4 □Donation 5 □ Other (Specify	)	Met	ropoli				200	7			Virginia
Depermit Deperment Import	eny in		21. Signature of Tuneral Service Licen	See Cle	,	1					uneral			
			23a. Part1. Enter the disease, or comp	olications that cause	d the death	h. Do not ent	O Un: er the mo	Lvers de of dying	ity I g, such as	cardiac o	W, Si	lver	Spring	Approximate Interval Between
Physic	ian		shock, or heart failure. List only ( Immediate Cause (Final disease or condition	ATHERO		ROTIC	CA	RAID	VAS	01.6	HR I	HISE	ASE	Onset and Death
/Medi Exami	ical		resulting in death)	Due to (or as					- ,, - <	24/4	, ,	), = -		
LAGIIII		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):								
outed by	ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
ate be executed hysicien and	ourial-t		resulting in death) Last	Due to (or as	a conseq	uence of):								
icate b	s the to	dical	•	d										
o certif	use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			]Ectopic p						23d. Date of de	•
Physician: The law requires thet the death certificate be executed this certificate hes been signed by the attending physicien and	thed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (s						Month	Day Year
thet the	a detac	by Ph	Part II. Other significant conditions co	ontributing to death	out not res	ulting in the u	nderlying	cause give	en in Part	1.	23e. Did	tobacco u	use contribute t	to the cause of death?
w requires been sign	סחום	ed b	SARLOMA UF	ABDO	omE	N					1 🗆	Yes 2	□ No 3 □ P	robably 4 Dinknown
law n	9 2 sh	Completed	HORTIC STI	ENOSIS							24a. Was	psy	24b. Were a	utopsy findings available completion of cause of
The The	r, pag			UFFICIE	1Cep						1 ☐ Yes	ormed? 2 No	1 ☐ Ye	s 20 No
/sicial	Jir <b>e</b> cto	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1   Inpat	ent 2	ER/Outpatien	ıt 3□ D	OA Othe	00		n <i>(Check only</i> me 5 ☐ Res		6 ☐Other (Sp.	ecify)
ter this	neral		27. Manner of Death	28a. Date of Inj (Month, D		28b. Time of		28c. Injury Work			28d. Describe			,
storic Afte	the to	catle	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🗆		20f Legation	(Street as	ad Alumbar or F	Rural Route Number,
efter of Director	d in by	Certification:	4 Homicide determined	286. Place of Ir	tc. <i>(Specif</i> )	ome, tarm, str y)	eet, factor	у, опісе			City or To			ndra: Houle Number,
To the Hospital or Attending Physician: The law requires thet the death certificate within 24 hours efter death.  Very the Funeral Director: After this certificate has been signed by the attending phys.	etely fille	Medical C	29a. Certifier 1 Cartifying Ph (Check only one)	ysician: To the besi ninar: On the basis and manner s	of examina	owledge, death	n occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s)	) and manner a d place, and du	is stated. le to the cause(s)
Withir th	COM	Me	29b. Signature and title of certifier	1				c. License				1	te signed (Mor	nth, Day, Year)
15			Jasnew C	talha	en			1)28	3595			11/2	olot	
			1AS NEEM LA	CHANI, 2	835	Smit		rE,	Sur	TE '	203, 1	BA	uro m	) 94289°
Re	Sta gistr		31. Date filed (Month, Day, Year)	32. 10915	rar's Signa		est.	8						

Furrier

King David Mem. Grdns 11/20/2007

22. Name and Address of Facility

20b. Place of Disposition (Name of cemetery, crematory or other place)

16b. Kind of Business/Industry

Falls Church, VA

Retail

18. Mother's Name (First, Middle, Maiden Surname)

Mary Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10811 Hidden Trail Court Potomac MD 20854

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he access once. Baltimore, Maryland 21215-0036

Be

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

30. Name and address of person who completed crose of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 2 1 2007

Ava Kaufman MD 8219 Wisconsin Avenue #103 Bethesda MD 20817

College (1-4or 5+)

Elementary/Secondary (0-12)

Max Schwartz

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print) Linda Snyder - Daughter

21. Signature of Funeral Service Licensee

**Funeral** 

Director

Physician /Medical Examiner

attending physician and for use as the burial-tran The law requires that the death certificate be exec To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Danzansky-Goldberg Memorial Chapels Inc II/O Rockville Pike Rockville MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sudden Cardiac Death disease or condition resulting in death) Due to (or as a consequence of): Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) □Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√√ No autopsy performed? 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert D26259 November 19, 2007

DHMH 17 Rev 1/2001

State

Registrar

24 hours a

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f sh Examiner must be notified

Item 27 Is marked other other traumatic event,

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once.

Directo

Funeral

Completed by

Be

မ

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine by Physician/Medical Be Completed Medical Certification: To

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition	PREUM	ONIA			DATS - WEEL
resulting in death)	Due to (or as a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events	b				
resulting in death) Last	c.  Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic pregnancy ]Other <i>(sp</i> ec <i>ify)</i>		23d. Date of de Month	elivery Day Year
	s contributing to death but not resulting in the u		23e. Did tobacc		to the cause of death? Probably 4 □ Unknowr
			24a. Was an autopsy performed 1□ Yes 2 🗹	2 death?	autopsy findings available completion of cause of s
25. Was case referred to medical		26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Sp	ecify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)  28b. Time o Injury		28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		eet, factory, office	28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
	Physician: To the best of my knowledge, deat aminer: On the basis of examination and/or in and manner stated.				
29b. Signature and title of certifier	/_	29c. License number	29d.	Date signed (Mor	nth, Day, Year)
· ///	////	02649	19	11-25	-07

Mt. Airy, MD 21771

Registrar DHMH 17 Rev 1/2001

within 24 hours after death

To the Funeral Director;
completely filled in by the

4 Culwell Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Ronald E. Miller

DEC 0 6 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2:20 P. M. **Physician** Ruth Evangeline Walker lovember 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🕅 82 06/03/1925 213-24-7616 VA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1XIYes 2 □ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or US 21742 1110 Outer Drive Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married **Black** Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify Specify. à 3X Widowed 4 ☐ Divorced Completed the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than Lry or other traumatic event, the M Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amanda (unk) Wood Edison Henshaw Gaines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1110 Outer Drive, Hagerstown, MD 21742 Edison R. Walker / Son Department of Health a Important: If item 27 is any injury or other tra once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/2007 Hagerstown, MD Rose Hill Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a considerace of): **Physician** 540grs /Medical Examiner 2 month ebroif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last anolithnos tell ellethneup Due to (or as a consequence of): Examine death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2 X No 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[**X**No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28c. Injury at Work? Certification: Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hegerston MD21740 Strall-368 DSHAM. 35H-4 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director MD

Funeral

þ

Completed

Be

မ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical France.

Medical Certification: To Be Completed by Physician/Medical Examiner signed by the nours after death.

neral Director: A
filled in by the for

Division or Vital Records, P.O. Box 68760,

shock, or heart failure. List only Immediate Cause (Final			, ,	Interval Between Onset and Death
disease or condition resulting in death)	a. Non Small Cell Carci Due to (or as a consequence of):	noma of the Lun	g	12 months
Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):			
that initiated events resulting in death) Last	CDue to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2∑ No 9 □ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			th (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	3 □ DOA Other: 4 □ Nursing H	ome 5 🔀 Residence	6 ☐Other (Specify)
27. Manner of Death 1X Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not l 4 Homicide determined		factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place tigation, in my opinion, death occu	, and due to the cause( irred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Wendy B.

31. Date filed (Mon.

Bldg.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernstein, M.D.

Rm 5105

Pigistrar's Signature

MD040668-E (PA)

8, NNMC Bethesda, MD 20889

2007

10.1	,	1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death
Physicia /Medica	- 11	Mary Russell Wenger	•				Novemb	er 19.	Year 2007	10:30 A <sup>M</sup>
Examine		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death			unty of Death	
	1	3703 Dunlop Street			Chevy Ch	nase		Mont	gomery	
Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bi	rth	9. Birthr	place (State or Foreign
Director		579-22-8007	M 2 <b>X</b> ]F	35 Yrs.	Monato Baye	THOUSE INTE	Jan 13	, 1922	0kla	
pu »		Usual Residence of Decedent  10a. State 10b. County	10c Cib	, Town or Lo	neation				1	10d Ingido City Limita
aryla shov	<u>_</u>	Toa. State Tob. County	100. 010	y, TOWITOI EC	Cation					10d. Inside City Limits 1 ☐ Yes 2 \ No
Ba-f otifie	Director	Maryland   Montgomer	y Cher	vy Cha						
vith the		10e. Street and Number			10f. Zip Code				of What Cour	ntry?
s 238	ra	3703 Dunlop Street		0 140	20815		- 17 11	USA	Race - Americ	an Indian
er de item	Funeral		I2. Was Decedent Ever in U. Armed Forces?	5.   13.	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	0- 14.	Black, White,	
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Sp	pecify:	±0
hou sal E	- G	15. Decedent's Educ		16a. Dece	dent's Usual Occup	oation		16b. Kind	Whi of Business/In	
n "ng	Completed	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of world)	king			,
with jene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Execu	tive Assi	istant		Const	ruction	n
filed I Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ө (First, Middle			
lid be lenta rked the ex	ToE	(unk)	Rand	le		Inez Mil	ler			
shou and A s ma uma		19a. Informant's Name/Relationship (Typ	oe. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	ber, City or To	own, State, Zip	Code)
alth a		Charles E. Wenger/s	son	8303	Ellingso	on Dr. Ch	evy Cha	se, MD	20815	
item of He		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other pla	ce)	Date	20c. Locat	ion - City or To	own, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )				ory 11/2	1/07	Belts	ville,	MD
mit. partn porta y inju		21. Signature of Funeral Service License		2:	Name and Addre			ico D	O Por	784
B B B B		Bough I Ha	MO.		-					e, MD_2102
100		23a. Part1. Enter th  sease, or complice shock, or heart failure. List only on	cations that caused the death	n. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final	Cardiomyopat							Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence							
Examiner			Chronic Obst	ructi	ve Pulmor	nary Disea	ase			
	je	Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ							
cuted nd ransi	Examiner	that initiated events								
		resulting in death) Last	Due to (or as a consequ	uence of):						
cate be executed physician and the burial-transit	<u>g</u>	d	,							
certificate be executed rding physician and use as the burial-transit	cian/Medical	IF FEMALE:						1		
ath certific attending pl for use as t	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3[	∃Ectopic pregnanc	у		23d	I. Date of delive Month	ery Day Year
e dea		1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐Unknown	eath 5	Other (specify) _				MOUTH	Day Tear
law requires that the death as been signed by the atter 2 should be detached for u	Physi	9 ☐ Unknown  Part II. Other significant conditions con	tributing to dooth but not roo	ultina in the co	ndorbina asusa sir	con in Florid I	220 Did	tobacco uso	contribute to t	he cause of death?
res the signer pe d	2	Tarri. Other significant conditions con	and any to death but not rest	alling in the u	ndenying cause giv	veri in r ait i.				bably 4 □Unknowr
w requires been sign should be	Completed							163 2 <u>A</u> 1	10 3 F10	Babiy 4 Donkhowi
law lasb	e d						24a. Was	DDSV	prior to co	opsy findings available impletion of cause of
The laste has page	5						perf 1□ Yes	ormed? 2 X No	death? 1 ☐ Yes	2□ No
sician: The certificate irector, pag	Re	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
Physical this call dire	0	14103 ZIII0		ER/Outpatier		4 ☐ Nursing H	ome 5 <b>X</b> Res			fy)
ding P	.:   	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury o	ccurred	
ternd eath. tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
or Attending Physician: ifter death. Trector: After this certifica in by the funeral director.	Certification:	4 Homicide determined	28e. Place of injury - At he building, etc. (Specify	ime, farm, str //	reet, factory, office		28f. Location (	(Street and N own, State)	lumber or Run	al Route Number,
urs a		One Contifier 4 M C - 1/4 1	Jalan Ta Harbard		h					-1-1-d
To the Hospital or Attendi within 24 hours after deaff To the Funeral Director: A completely filled in by the fu	Medical		ician: To the best of my kno ner: On the basis of examina							
the the mple	Med	29b. Signature and tille of gertifler	and manner stated.		29c. Licens	se number		29d Date e	signed (Month,	Day, Year)
5.½ ₹ 8					D5224				er 19,	-
60	1	Lord Ulm	> .	00-1 7		T /		MOVEIIID	IJ,	2007
Sept.		30. Name and address of person who con		, , , , ,		IO1 Rotho	oda MD	2081/		

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0310 14 2007 Brenda S. Young November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, U1y 25 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√□ F D.C. 58 Yrs. Director 219-54-4807 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Dea1e 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5506 Nutwell Sudley Rd. 20751 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married A Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 2yrs <u>Care Giver</u> Department of Aging nd 2 should be filed wath and Mental Hygie 27 is marked other tirtanmatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Windsor Mary Easton ပ permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deale, Md. 20751 Eugene W. Young (Husband) 5506 Nutwell Sudley Rd. 20c. Location - City or Town, State 20a. Method of Disposition 200 Place of Disposition (Name of + 1) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery 11-19-07 Brandywine, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Windlame Reduces of Sacilicons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 MC0483 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or he consequence of Examiner Sequentially list conditions, if any, leading to intrive late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a nonsequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 NO 2 R/Outpatient P 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1- Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident

death certificate be executed Division or Vital Records, P.O. Box 68760

within 72 hours after

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit signed by the a this certificate has been ral director, page 2 should funeral

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After completely filled in by the funer. Certification: Medical

> State Registrar

	On the basis of examination and/or inve and manner stated.		at the time, date and place, and due to the cause(s)
Signature and title of certifier	ier as	29c. License number D1 6 37 6	29d. Date signed (Month, Day, Year)

6 ☐ Could not be

determined

3□ Suicide

29a. Certifier

29b. Signa

4 ☐ Homicide

🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

39. Name and address of person who completed cause of death (Item 23a) (Type Joseph Mosemp, 2001 We divad 1 Brugolis MD 21401 31. Date filed (Month, Day, Year)

Registrar's Signature NOV 1 9 2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

	within 24 hours after death.	To the Hospital or Attanding Divisions. The law requires that the death configurate he executed
--	------------------------------	---

		for State Registrar		State of	Maryla		partment of F <i>ertificate of</i>				giene Reg. No.	2007	39123	
5	177		e (First, Middle, La	st)					2.	Date of Dea	ath		3. Time of Death	
Physicia /Medic		Antoine		ared						ovembe			7:00 AM	
Examin	er	4a. Facility Name ( <i>I</i> Suburban	If not institution, giv	e street and num	ber)		4b. City, Town, o		of Death			County of Death Ontgomer	7	
F		5. Social Security N	1	ex 7	7. Age (In yrs	last hirthd			r 24 Hrs.   8.	Date of Birt	h	0 Birth	place (State or Foreign	
Funeral Director		578-11-19	02	ex XM 2□F		2 Yrs	Months Days	Hours	Min. Ju	in 27, 1925 Lebanon				
how		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or	Location	<del>-</del>					0d. Inside City Limits	
Ba-f s	Directo	Maryland	Montgome	ery	Bet	hesda							1 ∐ Yes 2 ZANo	
3a or 2 st be no		10e. Street and Nu 6100 John		ıe			10f. Zip Code 20817				10g. Citi: USA	zen of What Cou	ntry?	
r mus	Funeral	11. Marital Status	· · - ·	12. Was Deced	dent Ever in U	J.S. 1	Was Decedent of H     If Yes, specify Cub	lispanic Or	rigin? (Specif	y Yes or No-		14. Race - Americ		
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ones.	β	1 ☐ Never Marr 3 ☐ Widowed	ied 2  Married 4  □ Divorced	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	9		1 ☐ Yes 2 X No	Specify		can, etc.)		Black, White, Specify: White		
"natur dical	eted	(Spec	15. Decedent's Ed	ducation de completed)		16a. De	cedent's Usual Occupive kind of work done e. DO NOT use retired	ation during mos	st of working		16b. Ki	nd of Business/In	dustry	
jiene. r than ' the Me	Completed	Elementary/Seco	ondary (0-12)	College (1- 4	4or 5+)		e. DO NOT use retire: nalist	d) -			Wire	e Service	2	
other orther	ø	17. Father's Name		)				18. Moth	er's Name <i>(F</i>	irst, Middle,	Maiden	Surname)		
Menta arked atic ev	To B	Rachid Ya	red					Lisa	Lisa Mezher					
h and 7 is m raum			ame/Relationship (			- 1	ailing Address (Street						Code)	
Healtl em 27 ither t		Roberta Y		2	20b.	Place of Dis	O Johnson sposition (Name of	i	Bethes				own State	
ment of ant: If It lury or o		1 ☐ Burial 2	XCremation 3 ☐ 5 ☐ Other (Specif		cemetery, crematory or other place) Chesapeake Crematory 11/21/07 Beltsville, MD									
Import any in once.		21. Signature of Funeral Service Licensee  Going and Address of Familiation Service P.O. Box 784  Beverly L. Heckrotte, P.A. Clarksville, MD 21029												
1		23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death												
ysician		Immediate Cause (Final disease or condition Aortic Dissection												
Medical		resulting in death)			r as a conse									
aminer	<u>.</u>	Sequentially list co if any, leading to in	nditions,	b. — Due to (o	r as a conse	guence of):								
d ansit	Examine	cause. Enter Under Cause (Disease or that initiated events	erlying injury			,						100		
attending physician and for use as the burial-transit		resulting in death) l		Due to (o	r as a conse	quence of):								
physic the b	edical			_d					,,,,					
nding use as	/Me	IF FEMALE: 23b. Was deceden	t prognant	23c. If yes, outo	ome pf pregr	ancy						23d. Date of delive	any.	
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Physician/Me	in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? ☐ No		th 2□Fet int at time of wn		3 □Ectopic pregnancy 5 □ Other (specify) _	/				Month	Day Year	
gned b	by P	Part II. Other signif	ficant conditions of	ontributing to dea	ath but not re	sulting in the	e underlying cause giv	en in Part	l.	23e. Did to	bacco u	ise contribute to t	ne cause of death?	
en sig										1 🗆 Y	′es 2 <b>X</b>	No 3□ Prot	pably 4 ☐Unknown	
te has be	ompleted									24a. Was a autop perfor 1∐ Yes	sy	prior to co	psy findings available mpletion of cause of	
rtifica tor, p	O	25. Was case refer	red to medical					26. Place	e of Death (C			1 ☐ Yes	2   N0	
nis ce direc	ල ස	examiner? 1 ∐ Yes 2 📉	No	Hospital: 1 ☐ In	patient 2X	] ER/Outpat	tient 3 DOA Oth	or.				6 □Other (Specia	iy)	
After th funeral	ion: T	27. Manner of Deat 1 XNatural	5 Pending		lnjury , <i>Day Year)</i>	28b. Time Injur	y Wor	y at k?	28d	I. Describe h			,,	
ctor: y the	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 □ Could not be		of injury - At h	ome farm	M 1 □ street, factory, office	Yes 2□	11 12	t ocation /S	Street an	d Number or Rura	al Route Number	
rs arter al Dire ed in b	Certification:	4  Homicide	determined		g, etc. (Speci		otroot, ractory, critical		201.	City or Tow			ir House Namber,	
n 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one)	1 X Certifying Ph 2  Medical Exam	ysician: To the b niner: On the bas and manne	sis of examin	owiedge, de ation and/or	eath occurred at the til r investigation, in my o	me, date a ppinion, de	nd place, and ath occurred	due to the at the time,	cause(s) date and	and manner as s d place, and due t	tated. o the cause(s)	
Nim Con Line	M	29b. Signature and	tifle of certifier	US			29c. Licens D5789					ember 20		
OF		30. Name and addr						n - · *		MD 00	017			
Stat	te	31. Date filed (Mag	snileld,	M.D. 10	Z13 Fe gistrar's Sign	TNWOO ature	d Rd. #100	Beth	iesda,	MD 20	QI/			
Registra	ar	31. Date filed (Man	IUV 2 1 2	JU/	wir.	1. M	parks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ADAMS Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Howard County General Hospital Months Days Hours Min. Min. March 31,1944 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 □ F 228-58-5468 63 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 U.S.A. 3222 Birchmede Drive Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Montgomery County ulth and Mental Hygiene.
27 is marked other than "
7 traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ariel Lee Adams, Sr. Dorothy Badgley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Adams (Wife) 3222 Birchmede Drive Ellicott City, MD 21042 Department of Health Important: If item 27 any Injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Garrison Forest 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-11-2007 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 22 Name and Address of Facility
Witzke Funeral Homes, Inc.
Witzke Funeral Homes, Columbia, MD 21045 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1□ Yes 2☑ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 \_\_mpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation nours after death.

Ineral Director; Af

y filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 ho To the Fund completely f and manner stated.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, DEC 0

32. Registrar's Signature

TIMORE and 2/201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0

Amend Item 8 per fh, g878, 04/08/08/08/09

Amend Item 8 per fh, g878, 04/08/08/09

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 950 PM BATTIFORA MA 12 2 -/Medical 07 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** A Penu 1 □ M 2 🛛 F 07/17/1946 76-502 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTO Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8eR4 21218 death 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2□ No White Specify. þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'any injury or other traument Elementary/Secondary (0-12) College (1-4or 5+) DisAble **Unk** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( UNK. UNK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UNK stacey TORRES 828 EUTAW N.20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12-5.07 DUNDAIK 1 ☐ Burial 2 Tremation 3 Removal from State Allview CREMATORY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease or complications that daused the death. Do not enter the shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) reavs /Medical Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ps ps 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Concer 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1☐ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours To the Funeral Medical 29a, Certifier 1💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24170 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPILE 838 Baltimore Tso MD N. Eutaw St 31. Date filed (Month, Day, Year)
DEC 0 7 2 State Registrar

toleter

9500m

DIED

VILMA BATTIFCAA

State of Maryland / Department of Health and Mental Hygiene

**Physician** /Medical Examiner **Funeral** Director filed within 72 hours after death with the Maryland r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director Completed by Funeral Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 Is marked other any injury or other traumatic event, # **Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760, the asn detached certificate Physician: director, this

as in by the funeral within 24 hours after death. To the Funeral Director: After Hospital or Attending completely filled To the

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 5:20p.M 30 2007 Alfred Bruce 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1√2 M 2 ☐ F 78 577-32-5919 Usual Residence of Decedent 29 NC 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ¥Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 3505 Sussex Road 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Black 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Interior Decorator 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Bell Railey Madison Odell Bruce ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 B610 Langrehr Road, Randallstown, Md Mary McCard-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln 12/6/07 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Immediate Cause (Final ARYNLEAL CARUNDMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS DRIVE REISTERSTOUN NO 21136 UMA 210 31. Date filed (Month, Day, Year) State 2007 Registrar

DHMH 17 Rev 1/2001

State Registrar

Linda

31. Date filed (Month, Day, Year)

Johns

DHMH 17 Rev 1/2001

**ORIGINAL** 

21224

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar Amend #17,perF	State of Ma	ryland / [ /08 TT		rtment e			and Me		giene leg. 10	07	39128
	Physici	an	1. Decedent's Name (First, Middle, Last, Margaret B.								2. Date of Dea		Year	3. Time of Death 12:10a M
	/Medic	al	4a. Facility Name (If not institution, give				4b. City, To	OF OWN	Location o		Dec 3		unty of Death	12:10a M
	Examin	er	Franklin Woods		Cento		•		lale	Death			ltimo	re
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last bir	rthday)	If Under 1	Year	If Under		B. Date of Birtl	<u> </u>	9. Birth	place (State or Foreign
ш	Director		213-20-5216	M 2[ <b>X</b> F	105	Yrs.	Months [	Days	Hours	Min.	Jan 1	1902	Мa	ryland
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	m or Loca	ation							10d. Inside City Limits
	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f show the Medical Examiner must be notilized at	jo	MD Balti	more	Too only, Too		kvil	le						1 ☐ Yes 2 🛣 No
	7.28a	Director	10e. Street and Number				10f. Zip Ci	ode				10g. Citizen	of What Cou	ntry?
	h with	a D	2528 Hillcre	st Avenu	.e		2	123	34			USA		
	ams	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Deceder	nt of His	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14.	Race - Ameri Black, White,	
36	s afte , or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X N If Yes, Give	0		☐Yes 2[		Specify:		,,			ite
9	hour turai	ed b	3 ₩Widowed 4 □Divorced  15. Decedent's Edu	Year or Dates:	169	Decedo	nt's Usual (	Daguna	tion				of Business/In	
15	d within 72 ho piene. r than "natu ine Medical	plet	(Specify only highest grad	completed)		(Give ki	ind of work	done di retired)	uring most	of working	9	TOD. KING C	n business/in	dustry
212	77 70 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		Home	make	r				own	home	
ם	be filed ttal Hygie d other evant, II	Bec	17. Father's Name (First, Middle, Last)	nnick					18. Mothe	r's Name	First, Middle,	Maiden Sur	name)	
yla		၉	Sebastian <del>Shi</del>	<del>nalick</del>					Kat	ie 1	Fidles	3		
Maryland 21215-0036	C1 (0 = 18		19a. Informant's Name/Relationship (Ty  Mary Kueberth			-					Route Numbe	-		
	an ealt		20a. Method of Disposition	/ uaugiit	20b. Place of				est	Avei			on - City or To	D 21234
nor	Pages nent of I int: if its iry or o		ty☐ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	Garde	ry, crema	atory or other	er place	h ! 1	2/10			ville	
Baltimore,		H	<ul><li>'4 □Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	90	0012 010		Name and		1					
B	permit. Departrimports any inju		Patrick R	Pen	1					300	Mace l Home			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do								Lissen	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Den	1 porti	/1	FV	11-	54	2 0 6	2			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of): )	-V	ju .		ng E				
Н	Examine	_	Sequentially list conditions,	).		-	Mary and a secondary							
	ted	nlne	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	เรียกร้อดูนอกเอย	orj.								
_6	axecurand al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence	of):								
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dical E		ı										
9	tificat ig phy as th	ledi												
Вох	leath certific attending p	an/N	200. Was decedent pregnant	3c. If yes, outcome of		. 3∏E	ctopic pregi	nancy				23d.	Date of delive	•
	of the dea by the at tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at t			Other (speci						Month	Day Year
P.0	- 0 0		Part II. Other significant conditions con	tributing to death but	t not reculting in	o tho und	larhina oau	50 ENO	io Bort I		23a Did to	hacco uso (	andributa to t	ne cause of death?
Records,	uires tha signed Id be del	d by	Anemia Co-	V 1971 1 4 4 1	CAT	-40		2 7	Par C4	2	1 U Y			pably 4 □Unknown
Sor	w requ been shoul	lete	The Child, Co	7			7	1.1.00			24a. Was a			psy findings available
Re	The law requires ate has been sign page 2 should be	ompleted			<u>_</u>						autop: perfor	sy med?	prior to co death?	mpletion of cause of
Vital		ပိ	25. Was case referred to medical						26 Place	of Doath	1 Yes	2 No	1 🗆 Yes	2 No
<u> </u>	Physician: this certific ral director.	To B	examiner?	ospital:	it 2□ER/Ou	utpatient	3□ DOA	Other			e 5 Resid	-	Other (Specif	v)
n of			27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of	28c.	Injury Work?	at	7.7	d. Describe h			.,
sio	Attending ir death. actor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2□N	No				
Division	for Attence after death Diractor: I in by the	Certification:	4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, fa . <i>(Specify)</i>	ım, stree	et, factory, o	office		28	If. Location (S City or Tow		imber or Rura	Il Route Number,
	Hospital   24 hours a Funaral C		29a. Certifier 1 Certifying Phys	ician: To the best of	f my knawledae	a death o	accurred at t	the time	date and	t place, an	d due to the o	21150(5) 220	l mannor as s	totod
	To the Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner stat	examination an	nd/or inve	stigation, in	my opi	nion, deat	h occurred	at the time, o	late and pla	ce, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1				number				gned (Month,	
	. 7		From John	non l	20-	1100	0	)40	576	6		Dero	in her	-62007
4	1 /		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (	(Туре, Рг	rint)		0		, 0	1.	0. (1)-1	1000
			Tom Edmond	Son 9105	Frank	lin	Syria	16	Dr.	H. 3	12,13	150	nove.	102/237
	Sta Registr		DEC 0 7 2007	12. Registra	s Sidpature	2306			,				,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Walter Michael Brumwell State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No. 2 1 7 3 9 1 7											121			
	Registrar  1. Decedent's Name (First, Midd	lle.Last)	Cert	cate or	Dealii		2. Date of De	Reg. No ath	UU	3. Time	of Death	16.		
Medical Examiner	Walter Michae						Month Novembe	Day Yea er 11, 2007	г	184	4 hrs			
( alex	4a. Facility Name (if not instituti		er)	4	b. City, Town, or L	ocation of De	ath	4c. County of						
`	Baltimore Washingto				Glen Burnie	Tara a		Anne Ar			Ct-t			
Funeral	5. Social Security Number		Age (In yrs. la:	st birthday)	If Under 1 Year Months Days		Hrs. 8. Date of E	Birth (MM/DD/YYYY	Foreig	gn	State or			
Director	214-56-1870	1 X M 2 F	60	Yrs.				/1947	Co	ountry)	MD			
any	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on					10d. Ins	side City L	imits		
<b>≱</b>	MD Anne	Arundel	Pasa	adena						1 🔲	Yes 2	No		
the Maryland a or 28a-f sh <u>uified at once</u>	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	nat Cou	untry?				
the Milified	31 Brookfield	Road			2112	2		USA				ŀ		
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	11. Marital Status	12. Was Decede			s Decedent of Hisp es, specify Cuban,				- Amer	rican India	an, Black,			
or ite		1 X Yes	2 No									ŀ		
s afte	3 Widowed 4 X Di  15. Decedent's Education (Sp	vorced If Yes, Give Year or Dates:	completed)		Yes 2 No									
2 hour "natr I Exar	Elementary/Secondary (0-12				ost of working life.		NOT use retired)							
5-0036 ed within 72 hour lygiene. other than "natt	12			Carpen			Construction							
5-0 led will Hygie I other the N	17. Father's Name (First, Middle				1			, Maiden Surname	)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Comple	Edward Victor  19a. Informant's Name/Relation			10h Mailine	Address /Street		E. Lock	erman umber, City or Tov	ın Stat	te Zin Co	del	_		
MD 21 d 2 should lth and Me n 27 is ma aumatic ev	Deborah L. Se							, MD 210		e, 21p 00	36)	- 1		
and 2 and 2 tealth item 2 traus	20a. Method of Disposition			Place of Dispos	ition (Name of cem		Date	20c. Location		or Town, S	itate			
nord ages 1 at: If other	2 Cremation 3 Removal from State crematory or other place)									/15/07 Baltimore, MD				
altin mit. P oartme portar ury or		Stallings Funeral Home, P.A. Pasadena, MD 21122												
R PP III	Bul d	Sten !	`	B11	1 Mounta	in Rd.	Pasade	na, Mb 2	<u>1122</u>	201110,	Γ•Λ			
Physician /Medical	23a. Part I. Enter the disease, of failure. List only one caus	or complications that cause e on each line	sed the death.	Do not enter the	he mode of dying,	such as cardi	ac or respiratory	arrest, shock, or he	art		oximate Int			
xaminer	Immediate Cause (Final diseas or condition resulting in death)			2-						+	Death			
`		Due to (or as a co	onsequence or	) <del>.</del>										
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	Due to (or as a co	onsequence of	):										
led nsit Examiner	(Disease or injury triat initiated events resulting in death) Last	C	onsequence of	j):						-		$\dashv$		
executed an and al - transit		d	,,											
(0, e be executed ysician and burial - transit ledical Ex	UNPENDED	AMENDED	_											
6876( certificate nding physes as the b	IF FEMALE: 23b. Was decedent pregnant in		tcome of pregr		etal death 3	Ectopic pro	egnancy	23d. Date of Month	f delive	ery Day	Yea	ar		
x 68 h certi tendin use a	past 12 months?	4 Pregnan	t at time of de	ath -	ther (Specify)							Ш		
by the attentiched for us		nknown g Unknow					100- D	4 4 5 6 5 5 5 6 5 5 6 5 5 6 5 6 5 6 5 6	tributo (	to the cou	on of dogs	th 2		
tal Records, P.O. Box 6876/cian: The law requires that the death certificate certificate has been signed by the attending physector, page 2 should be detached for use as the Be Completed by Physician/MA	Part II. Other significant cond	litions contributing to d	eath but not re	esulting in the i	underlying cause g	iven in Part I.		d tobacco use cont Yes 2 ✔ No 3						
duires en sig											ndings ava			
Records,  The law require ficate has been signage 2 should be Completed								topsy rformed?		o completi	ion of caus			
ital Recitans: The secretificate rector, page					00 51	-( D+- /OL	1 ✔ Ye	s 2 No	1 🗸	Yes	2	No		
ital sician: s certi irector	25. Was case referred to medic examiner?	Hospital	patient 2	ER/Outpatien		Out	ursing Home 5	Residence 6	Oth	ner:				
n of Vital Records, ing Physician: The law requir After this certificate has been s funeral director, page 2 should on: To Be Completed	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Nursi 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?								rred					
on on sath.	O a let is								ıto					
FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other signifficant conditions  Contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 9 Unknown  Part II. Other signifficant conditions  Contributing to death but not resulting in the underlying cause given in Part I.  25c. Was case referred to medical examiner?  1 Yes 2 No  1 Yes 2 No  26c. Place of Death (Check of Injury at Work?)  1 Yes 2 No  27c. Manner of Death 1 Natural 27c. Manner of Death 1 Natural 28c. Date of Injury 1808 hrs  1 Yes 2 No  28c. Place of Injury 1808 hrs  1 Yes 2 No  28c. Place of Injury 1808 hrs  1 Yes 2 No  28c. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Local Street  28c. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Local Street  29c. Was case referred to medical examiner?  1 Natural 28c. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Local Street  28c. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Local Street  28c. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) Local Street								n (Street and Num n, State)	ber or I	Rural Rou	ite Numbe	r, City		
determined (Specify) Local Street								Road and Brooke			isadena ,	, MD		
in 24 h he Fur pletely	The standard of the standard o									tated. the cause	e(s)			
To the H within 24 To the Fe completel	29b. Signature and title of certi	and manner stat	ted.		29c. Licens			29d. Date sig						
~		() 20/1	1 /1		O.C.I	M.E.		Novembe	r 12,	2007				
	30. Name and address of person	on who impleted cause	of death (Item		1									
10		eputy Chief Medica			nn Street, Ball	timore, MI	D 21201							
State 31. Date filed (Month, Cay, Year) 2007 32. Registrar's Signature Registrar														

State

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar
DHMH 17 Rev 1/2001

Madison

NO 1411 W 32 Registrar's Signature Park Drive #16 Gen Burnie MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 04:25 AM Leeanna Fave Bradley DECEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE CITY ST. AGNES BALTIHORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, OCt. 22 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** <sup>Year)</sup>961 Months Min. 1 □ M 2 🖫 F Director 213-80-4603 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Pasadena Anne Arundel Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21122 USA 8470 Church Road "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 Is marked other than ' College (1-4or 5+) Manager Telephone Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miles Annallee Faaty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8470 Church Road, Pasadena, MD 21122 Daniel W. Bradley Sr. (spouse) permit. Pages 1 a
Department of He
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 12 Dec. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Glen Haven Cemetery Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC NON SHALL LUNG CARCINOMA Physician disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of): Examiner UN KNOWN SEIZURE DISORDER Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Records, P.O. signed by the 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s nerform performed? 1□ Yes 2 No this certificate 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P Division or 28a. Date of Injury 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 🕅 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE., ST. AGNES HOSPITAL MAGDALENA THENOUSA BALTINORE, HD, 21229

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

RADLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** J. BARTKOWIAK **JEAN** Dec. 01. 12:33 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 210 Winston Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year)
April 25,1942

9. Birthplace (State or Foreign Country)
West Virginia 5. Social Security Number 7. Age (In vrs. last hirthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖬 F 65 Director 212-40-4599 Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Pasadena Director Maryland 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? 21122 U.S.A. 210 Winston Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) EDISON Electric Co Elementary/Secondary (0-12) College (1-4or 5+) 10 n Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linkous ೭ Roland J. Abrams Agnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis A. Bartkowiak (Husband) 210 Winston Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayv dew Crematory 12-06-07 Baltimore, Maryland 21. Signature of Funer Lervice License 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic **Physician** una canc week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinsial cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence or, Examine certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): physician as the burial Physician/Medical use as nding IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Tes 2 No been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an page 2 s has autopsy performed / /es 2. No certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ိ 5 ☑ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. Ö Records, P. Division or Vital spital or Attending P nours after death. neral Director: After I y filled in by the funera To the Hospital of within 24 hours af To the Funeral D

0

Medical

DHMH 17 Rev 1/2001

Susan Easley, 31. Date filed (Month, Day, Year) State DEC 0 Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

24A Magothy Beach Rd. Pasadena, MD 21122 32. R

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

056741

29d. Date signed (Month, Day, Year)

2007

				For State	State	of Mar	yland		artment of			ental Hy	gien	e	001	00
	_			Registrar	/- / and)		-	Ce	rtificate of	Death	1	2. Date of De	Reg. N	2001	3. Time	J J
	m	Physicia	an	1. Decedent's Name (First, Middle								Month	D	ay Year		M
		/Medic Examin	'M'	Mahendra P. Bud 4a. Facility Name (If not institutio		number)			4b. City, Town,	or Location		Decembe	_	3 <b>2007</b> c. County of Dea	5:0	Z A
		Examin	ei	Suburban Hospit					Bethes	da				Montgom	ery	
		Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F		(In yrs. la	st birthday)	If Under 1 Yea Months Days	r If Unde	Min.	8. Date of Birl (Month, Da	y, Yea	9. Bir	thplace (State ountry)	or Foreign
	1	Director		466-02-1462	ILANIVI ZLIF		64	Yrs.				July 7,	, 19	943 In	dia	
		and w		Usual Residence of Decedent  10a. State 10b. County	/	1	10c. City,	Town or Lo	ocation						10d. Inside	Dity Limits
		Mary -f sho fied a	ţo	Michigan Genes	800		F1i	nt							1 <b>∑</b> Ye	s 2 □No
^		h the r 28a r notir	Directo	10e. Street and Number		1		110	10f. Zip Code				10g. C	itizen of What C	ountry?	
0		23a cust be	a D	3312 Pencombe P	lace				485					ited Sta		
M		er dea tems ner m	Funeral	11. Marital Status	Armed	Forces?		13.	Was Decedent of If Yes, specify Cu	Hispanic O ban, Mexic	rigin? (Spe an, Puerto l	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi	te, etc.	
12/3	36	rs afte	by F	1 ☐ Never Married 2 💢 Mar 3 ☐ Widowed 4 ☐ Divorced	l If Yes.	es 2 <b>X</b> No Give r Dates:	)		1□Yes 2⊠N	Specify	y:			Specify: As	ian In	dian
7	5-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ed	15. Deceder	nt's Education	- 41		16a. Dece	dent's Usual Occ	upation	nat af wartin		16b.	Kind of Business	/Industry	
1	215	thin 7; e. an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)		e (1-4or 5+) <b>5+</b>	)		kind of work don DO NOT use retii			ig		4.1		
4	2121	ed wil ygien ier th	2			<u>5+</u>		Віо	medical			/Final Ministra	<u> </u>	ealthcar	e	
\$	gue	be fill ad oth even	Be	17. Father's Name (First, Middle								(First, Middle		en Surname)		
502 As	Maryland	hould d Mer marke matic	۴	Petaiah Budanur  19a. Informant's Name/Relation		·		19b. Maili	ng Address (Stree			ma Gowe		or Town, State,	Zip Code)	
5	Ma	od 2 s lith an 27 is rtrau	9	Prabha Budanur/					Pencomb				-			
	re,	s 1 ar		20a. Method of Disposition			20b. Pla	and Diag				ber 7,		Location - City o	r Town, State	
Ex	E	Page nent c int: If iny or		1 ☐ Burial 2 ② Cremation 4 ☐ Donation 5 ☐ Other (		om State	Mon	tgóme mator	imatory or other p imatory or other p ium, Inc	;	20	07	Bet	thesda,	Maryla:	nd
9	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	e Licensee			B	2. Name and Add ethesda-	ress of Fac Chevv	ility Rob Chas	ert A. e. Inc	Pur	nphrey F 557 Wisc	uneral onsin	Home/ Avenue
115		80 = 80		100 E	811			346   B	ethesda,	Mary	land_	20814				
45				23a. Part I. Ernor he disease, c shock, or heart failure. Lis	st only one cause o	on each line	9.								Approxim Interval B Onset an	etween d Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CA.				Cardiova	scup	n di	sease			-	
00		Examiner			Due	to (or as a	consequ	ence or).								
	5-1	3	Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. Due	to (or as a	вопвады	ence orp								-
2 1	D.	ate be executed hysician and the burial-transit	Examiner	that initiated events	с											
7 0	Ö,	te be executed ysician and e burial-transi	Ä	resulting in death) Last	Due	to (or as a	consequ	ence of):								
4	8760	cate b	dical		d											
2	Box 68	ne death certifica the attending pland for use as t	/Me	IF FEMALE:	23c. If yes,	outcome p	f pregnar	псу						23d. Date of d	eliverv	
3	Bo	atten atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pr	ve birth 2 regnant at t			□Ectopic pregnai □ Other <i>(specify)</i>					Month	Day	Year
7	P.O.	law requires that the death certifical as been signed by the attending phy 2 should be detached for use as the	Physician/Med	9 Unknown	9□∪	nknown										
T	S, P	s that	by P	Part II. Other significant condit	tions contributing t	to death but	t not resu	Iting in the	underlying cause	given in Par	t I.			o use contribute		
JaH	ord	equire sen sig ould b	led 1									1 📗	Yes	2 No 3 I	Probably 4	
5	ec	law I	Completed									24a. Was		prior to	autopsy finding completion o	s available f cause of
	Vital Records,	ician: The lav certificate has ector, page 2										1□ Yes	2 🗷		s 2. ₹No	
2	VIII	Attending Physician: r death. sctor: After this certification of the funeral director.	B	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatien	. 0 34	-D/Outratia	ent 3□DOA	)thor:		(Check only		6 □Other (Sp		
7	o	Phys er this eral dir	5 To	27. Manner of Death	28a. D	ate of Injury	, T	28b. Time	III OLI DON	4 🗆 1		28d. Describe			lectry)	
7	ion	nding F ith. r: After e funera	tioir	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ing (// tigation	Month, Day	Year)	Injury		/ork? □Yes 2[	≥No					
ha	Division	r Attend er death. rector: / by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	:	lace of injur	ry - At ho	me, farm, s	treet, factory, offic	:0		28f. Location City or To	(Street wn, St	and Number or i	Rural Route N	umber,
Budha	Ö	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Cer													
2		Hosp 14 hou Fune fety fii	Medical	29a. Certifier 1 ☐ Certify (Check only cone) 2 ☐ Medica	ring Physician: To al Examiner: On the	ne basis of	examinat	vledge, dea ion and/or i	ith occurred at the investigation, in m	e time, date y opinion, d	and place, feath occur	and due to the red at the time	e, date	e(s) and manner and place, and d	as stated. ue to the caus	e(s)
B		o the ithin 2 o the omple	Med	29b. Signature and title of certify		nanner stat	ieu.		29c. Lice	nse numbe	r		29d. l	Date signed (Mo.	nth, Day, Year	·)
		F≯Fŏ		Bro	the	-			0	341=	74			12/3/	107	
	•	01		30. Name and address of perso	n who completed o	cause of de	ath (Item	23a) (Type		- / - 3	, ,				•	
		10		Dr. Robert Rot	hstein,	8600	01d	Georg	etown Rd	,, Be	thesd	a, MD	208	14		
			ate	31. Date filed (Month, Day, Yea	r) 3	2. Registra	r's Signat	ture								
	DU	Regist	-71	DEC_0	7 2007	There	<del>الما</del>	S A	Destil							
	DH	MH 17 Rev 1/2	:001					-								

ORIGINAL

1814511 ERD 502 Am 12/3/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2021350 of Mark 19874, Depay graps of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 7:55 PM DECEMBEL GENEVIEVE BARNES 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1910 Rencos Way Forest Hill Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🔀 F Director 217-09-5524 92 July 20, 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show notified at 1 ☐Yes 2X No Director Maryland Harford 28a-f Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 1910 Rencos Way 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be John (unk) Wachter (unk) Alexandra Michalik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar James Barnes IV / Son 1910 Rencos Way, Forest Hill, MD 21050 20b. Place of Disposition (Name of New Pates 1992)
Hilltop Cervice Corp. 12-7-07 20a. Method of Disposition 20c. Location - City or Town, State Picayure, MS Towson, M 1 M Burlal 2 <del>S©rer</del>ma 4 Donattion 5 D O 3 □Removel from State iny injury or Important: If r (Specify) 21. Signature of Funera 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a DISSECTING THORACIC ADRTIC ANEURYSM. Physician DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on Examine Due to (or as a consequence of): the burial-Records, P.O. Box 68760 physician Physician/Medical ast the attending for use a IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed 2 No 1\_ Division or Vital Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending M 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State DEC 07 2007

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LORRAINE OF ORI-AWUAH, NO 9106 PHILADELPHIA ROAD, STE 208. BALTIMORE, MD 21237. 32. Legistrar's Signature

fon-Houch, NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00061789

29d. Date signed (Month, Day, Year)

DECEMBER 4, 2007

			For State Registrar	State of Ma	ai yiai iu		rtificate of				eg. No.	3913		
44.	Physicia		1. Decedent's Name (First, Middle, Las		I [	Dorks	dala		2.	Date of Deat Month	Day Year	3. Time of Death 6:15 a M		
	/Medic		4a. Facility Name (If not institution, give	100000000000000000000000000000000000000	rd J. I	Daiks	4b. City, Town,	or Locat	ition of Death		Nov 27, 2007 4c. County of Death			
	Examili	CI		2403 Huron St	reet			Baltim	оге		N/A			
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. las		If Under 1 Yea Months Days		Inder 24 Hrs. 8. ours Min.	Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)		
	Director		227-40-6312	<b>Xy</b> 2□ F	74	Yrs.					7, 1933	Virginia		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits		
	Aaryk f sho ed at	ъ		N/A				Baltin	more		1 <b>XX</b> es 2 □ No			
	the 28a-	Director	10e. Street and Number	14//-4	1		10f. Zip Code			1	0g. Citizen of What Co	untry?		
	h with	al D	2403 Huron Street						21230		U.:	S.A.		
	filed within 72 hours after death with the Maryland Hygione. ther than "natural" or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of	Hispani ıban, Me	ic Origin? (Specif exican, Puerto Ric	y Yes or No-	14. Race - Amer Black, White			
0	amine		1 Never Married 2 Married	1 XYes 2 □ I If Yes Give	No 19		1 □ Yes 2 N		ecify:		Specify:	Black		
Š	hours tural" al Exa	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		55 Dece	dent's Usual Occ	unation			16b. Kind of Business/l			
2	in 72 "na" n	olete	(Specify only highest gra	de completed)		(Give	kind of work don DO NOT use reti	e during red)	most of working			-		
7	i with jene. r thar the N	Completed	Elementary/Secondary (0-12)	College (1-4or 5	0+)			Pole N	<b>Maker</b>		Locke	Insulators		
2	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			-		18. N	Mother's Name (F	First, Middle, I	Maiden Surname)			
0	should be filed with and Mental Hygiene s marked other tha umatic event, the I	To E		Barksdale							ia Inez Barksdal			
0	and sand		19a. Informant's Name/Relationship (7	Type. Print)			•				r, City or Town, State, Z	(ip Code)		
2 1)	1 and 2 Health em 27 l		Cheila Barksdale Daug 20a. Method of Disposition	ghter	20h Pla		915 Masefie osition (Name of	eld Ro	ad Baltimore		20c. Location - City or	Town State		
5	ages in the straight of the st		1 A Burial 2 ☐ Cremation 3 ☐		cen	netery, cre	matory or other p			12/03/07		sville, Md.		
Dallillo	artmel artmel ortant Injury		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		108 75		ville Veterar  2. Name and Add		includy	12/03/01	CiOWik	Sville, IVIU.		
0	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		1/2/	K)"	000 10		Este	p Broi	thers Funer	al Service	P. A.			
ľ	8		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not en	ter the mode of d	ying, suc	w Place Bal ch as cardiac or r	espiratory arr	est,	Approximate Interval Between		
v	Physician		Immediate Cause (Final disease or condition	Con	sest	rive	- Hca	15	fairle	ere		Onset and Death		
ĵ.	/Medical		resulting in death)	Due to (or as	conseque	nce of):			1					
	€xaminer	_	Sequentially list conditions,	b. Hy/a.	rter	<u>~ S/</u>	on							
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	rice oi):								
	xecut and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as	a conseque	nce of):								
00/00	ificate be executed g physician and as the burial-transit			d.										
00		ledical												
O	th certi ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	pf pregnand 2 □ Fetal d	cy leath 3	⊒Ectopic pregna	ncy			23d. Date of del Month	ivery Day Year		
	e dea he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of dea	ath 5	Other (specify)		-		Worter	Day Teal		
٦	w requires that the death certif been signed by the attending should be detached for use a		Part II. Other significant conditions of	ontributing to death h	nut not result	ina in the u	inderlying cause	given in	Part I.	23e. Did to	bacco use contribute to	the cause of death?		
as,	signe signe d be d	l by					, ,			1 □ Y	es 2 No 3 Pr	obably 4 Unknown		
ecords,	v requ	Completed								24a. Was a	an 24b. Were au	utonsy findings available		
	he law e has b ige 2 sh	dmo								autop: perfor	med? death?	utopsy findings available completion of ause of		
VITAIL IN	an: T lificate or, pa		25. Was case referred to medical					26.	Place of Death (		2 No 1 ☐ Yes	2₽No		
	ysicls is cer direct	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatie	nt 3□ DOA	Other:			ence 6 ☐Other (Spe	cify)		
0	ng Ph ter thi		27. Manna of Death 1 Natural 5 Pending	28a. Date of Inju		28b. Time o	of 28c. Ir	ijury at Vork?	28	d. Describe h	ow injury occurred			
0	endlr. eath. or: At	atic	2 ☐ Accident investigation						2 □No					
UIVISION	or Att	Certification:	3 Suicide 6 Could not be determined	200. Flace of III	jury - At horr tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office	ce	28	f. Location (S City or Tow	Street and Number or Ri n, State)	ural Route Number,		
_	To the Hospital or Attending Physician: The law within 24 hours after cleath.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	vsician: To the hest	of my know	ledge, dea	th occurred at the	e time, d	late and place, an	d due to the	cause(s) and manner as	s stated.		
	e Hos 24 hc e Fun letely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner si	of examination	on and/or i	nvestigation, in m	y opinio	on, death occurred	at the time,	date and place, and due	e to the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Lice	ense nun	mber	2	29d. Date signed (Mont	th, Day, Year)		
	1		25377	diril	~	0	Do	200	1049		//	-29-2007		
	8		30. Name and address of person who	completed cause of					Δ		inthicum n			
	Sta		31. Date filed (Month, Day, Year)	32: Regist	rar's Signatu	518 re	CAMP	) M	leade 16	-d (	inthicum n	nd 21595		
		110	[		- 3									

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:10 P M 2007 Fay Boggs Nov. Dorothy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert County Nursing Home Prince Frederick Calvert 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 X X 08-07-1930 Ohio Director 216-28-3789 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Intent of Heath and Mental Hygiene. Intent if Item 27 is marked other than "natural", or items 23a or 28a-f show this If Item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral United States 71 Rockywood Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Ir Black, White, etc. 11. Marital Status 1 Never Married 2 Mamied Specify: White 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Osborne Ollie F. McGraw ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockywood Lane, Baltimore, MD 21221 Forest L. Boggs- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 11-27-2007 | Elkridge, MD 5 Other (Specify) Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 21. Signatura MQ0053 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HRONIC Physician SBSTRUCTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or se a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 112 Yes 2 □ No. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform this certificate 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 [2] No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1 Natural To the more after death. To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

 $\mathcal{O}$ 

110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

NIE

DEC 0 7

40370

Hosp. Dr. # 310, Prince Frederick, UD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #20b, perFh, g874, 12/7/07 TT Certificate of Death Reg. No. U Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:15pm Sara Louise Caldarelli 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Harford Memorial Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virgini If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 🛭 F Months Hours 67 Virginia 235-62-3950 Director Usuel Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 ehov other traumatic event, the Madical Examiner must be notified at Harford Havre de Grace 1 ☐ Yes 2X No MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 United States 17 North Earlton Road Ext. iteme 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No ō 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sachs Fifth Ave. H.R. Rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked of peq. William R. Cotts Dorothy C. Kirker should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 permit. Pages 1 end 2 Department of Health a Importent: If item 27 is eny injury or other tra once. 145 Frank Drive York, PA. 17402 Scott Caldarelli / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD. 12/4/2007 Chapel-Bel Air 22. Name and Address of Facility
Evans Funeral Chapel & 21. Signature of Funeral Service Licensee Cremation Service: Hill, MD. 21050 ZD 3 Newport Drive Forest Hill, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. Eist only one cause on lach line. Immediate Cause (Final Physician WU G disease or condition resulting in death) /Medical Due to (or as a consequence of): ardiovascular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 Examiner attending physicien and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Yes 2 No 3 Probably 4 Unknown Division of Vital Record Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has autopsy performed! Yes 2 No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2010 Certification: To Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Matural 5 Pending efter death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerei D Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

AI DAREL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

DEC 0 7

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rles Conigland	4		tate	e of Maryla	nd / Depa	artment of rtificate of	Health and	l Menta	al Hyg		eg. No.	20	0.7	3913	
	Re	For State gistrar Decedent's Name (First, Mic	Idlo I d	act)		tiricate or	Death			. Date of Dea	th	Veer.	3. Time of		
Physician/			iule,La	351)		Coni	igland	l l	Month Decembe	r 1, 2007	Year	0048	hrs		
examine	45	harles  a. Facility Name (if not institu	tion, q	ive street and nur	mber)		4b. City, Town, or I	Death		4c. Cour	nty of Deat	th			
	40	St. Agnes Hospital				_	Baltimore C	ity							
Funeral	5.	Social Security Number	6.	Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year			8. Date of Bi	rth(MM/DD/Y	I HOTE	uan		
Funeral Director	1	1.01	1	X M 2 F	75	Yrs	Months Days	Hours	Min.	01 2	3 32	С	country) M	D	
		217-24-1442 sual Residence of Decedent		<u> </u>	- 75								10d Insid	de City Limits	
any	_	0a. State 10b. Coun	_		10c. City	, Town or Loca								es 2 No	
<u> </u>	_	MD NA				Balti	more				-	C14/1: -1 O-			
sa-f s	1 إ	0e. Street and Number					10f. Zip Code				10g. Citizen of What Country?				
or 23		1534 Poplar	G	rove St	reet		212	216			Yes or No- 14. Race - American Indian, Bla				
n with the Maryland ms 23a or 28a-f show be notified at once.		1. Marital Status		12. Was Dec	cedent Ever in t	J.S. 13. W	as Decedent of His Yes, specify Cubar	spanic Orig	gin? ( Spe , Puerto l	ecify Yes or N Rican, etc.)		Race - Ame White, etc.		I, Didok,	
leath ritem	Luneral	Never Married 2		1 Yes	2 X No	"					Sne	cify: =			
after d				ced If Yes, Give Yes		1 1	Yes XX No			ork done	done 16b. Kind of Business/Industry				
ours a	Completed by			pecify only highest grade completed)		16a. Decede	most of working life	nt's Usual Occupation (Give kind of w nost of working life. DO NOT use retir		red)					
6 172 h an "n cal E	ete	Elementary/Secondary (0-	12)	na	1-4 or 5+)	Co	nstruct	ion	Wor	ker	Con	ıstrı	actio	n Co.	
withir iene.	ĔĹ	6th grade  17. Father's Name (First, Mic	ا ماما				1	18. Mothe	r's Name	(First, Middle	, Maiden Sur	name)			
Hygind of the		17. Father's Name (First, Mic	iale, L	Un]	known			Man	30 0	ronial	and -				
D 21215-0036 should be filted within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "matural", or items 23a or 28a-f she natite event, the Medical Examiner must be notified at once in the Medical Examiner must be not the Me	8	19a. Informant's Name/Relat	ionshi	p (Type, Print )							and umber, City o				
Shoul shoul and N	_	Shirley Cor			ife	1534	Poplar osition (Name of co	Gr	ove	Stree	et, Ba	lto	Md_	21216	
and 2 lealth a	- 5	20a Method of Disposition			200	D. Place of Disp crematory or		emetery,		Date	20c. Loca	ation - City	or town, Si	tate	
Ore ges 1 t of H : If i	ч	1 X Burial 2 Crem			from State	Trini			12/	/7/07	Balt	imo	re, M	ld	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traument	1	4 Donation 5 Other 21. Signature of Funeral Ser	r Spe vi <b>et</b> L	icensee			Name and Addre	ss of Facili		7.0					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", injury or other traumatic event, the Medical Examiner.	Ť	(Xel, 1)	1/1	11ch		43	300 Waba	ash	sı Ave	Balt	imore	<u>&gt; M</u>	d 21	215 eximate Interval	
ysician	-	23a. Par I. Enter the diseas	е, Т	mplications that	caused the dea	ath. Do not ente	r the mode of dyin	g, such as	cardiac (	or respiratory	arrest, shock,	or neart	Betw	een Onset and Death	
ledical		failure. List only one commediate Cause (Final dis		<sub>a.</sub> Lung Can	cer								_	Death	
⊏xaminer		or condition resulting in dea	th)		a consequence	e of):									
		Sequentially list conditions,		b. Due to for as	a consequence	e of):									
	ine	if any, leading to immediate cause. Enter Underlying Co	ause	C.	a consequent								_		
	Examin	(Disease or injury that initial events resulting in death)	ted .ast	Due to (or as	a consequenc	e of):							1		
e executed cian and riral - transit				d											
be execut	dical	UNPENDED		AMENDE					_		23d.	Date of del	livery		
Box 68760, e death certificate by the attending physic ed for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnar	it in th		s, outcome of p	regnancy 2	Fetal death	3 Ecto	pic pregr	nancy	N	onth	Day	Year	
68 certif	cian	past 12 months?			egnant at time o		Other (Specify)				. ()			- 3	
30X death le atte	ysic	1 Yes 2 No 9			known					1220 5	Vid tobacco US	e contribu	ite to the cau	use of death?	
D. Bo tt the de lby the tached f		Part II. Other significant of				ot resulting in t	he underlying caus	se given in	Part I.		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 ✓ Unknown				
cords, P.O. B aw requires that the d has been signed by the should be detached	Completed by	Hypertension; Al	zhei:	mer's Demen	tia					- L	Vas an			findings available	
ds,	ete									a	utopsy erformed?	pric	or to complete	tion of cause of	
COL law e law e has le has lee has las	ldm									1 🗆 🕽	'es 2 ✔ No		Yes	2 No	
tal Re( tian: The certificate ector, page		25. Was case referred to n	nedica		-		26.P			ck only one)					
Vital Rec ysician: The l his certificate I	Be	examiner?		Hospital: 1	Inpatient 2	≥ ✓ ER/Outpa	tient 3 DOA	Other <sub>4</sub>	Nur	sing Home 5			Other:	100	
	5	1 Yes 2 N 27. Manner of Death	0	28a. D	ate of Injury onth, Day, Year)	28b. Time	e of Injury 28c.	Injury at W		28d. Desc	ribe how injur	y occurred	d		
on of nding Pt th. r: After ie funera	ion	1 V Natural 5		ding			1	Yes 2						City	
isic Atter or dea rector by th	icat	2 Accident	1	estigation 28e. F	Place of Injury -	At home, farm,	street, factory, offi	ce building	j, etc.	28f. Locat or To	ion (Street ar wn, State)	id Number	or Rural Ro	oute Number, City	
Div tal or al Dia led in	Certification:	3 Suicide 6 Homicide	dete	ermined (Spec	cify)					1					
Jospi Jospi 4 hou Funer ely fil		29a Certifier	/ing P	hysician: To the	best of my kno	wledge, death o	occurred at the time	e, date and	d place, a	and due to the	cause(s) and	d manner a ce. and du	as stated. ie to the cau	se(s)	
Division of To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After templetely filled in by the funeral	Medical	one) 2 Medic	al Exa	aminer:On the ba	isis of examinat	tion and/or inve	stigation, in my opi	nion, deat		at the time,			d (Month, D	lav. Year)	
To To Cour	Ĭ.	29b. Signature and title of	certifi		$\sim$			cense num	ner.			ember 1		** **	
		( ) An	1/2/	solell	ul)		0	.C.M.E.			Dec	enibei i	., 2007		
		30. Name and address of	perso	n who completed	cause of death	(Item 23a)		_16!	MD	1201					
7		Laron Locke MD		Assistant Med	dical Examir	ner 111 F	enn Street, B	aiumore	, IVIL) Z						
	tat	175	Year	7 2007	2. Registrar's S	-	ABAR								
Regis	3125		U		Lander	-	4								

OCME

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		Otate 0	1 Waiyia	Ce			Death	IIQ WEII	-	Reg. No.	007	39140
	Dhusiai	200	Decedent's Nar			_						Date of De. Month	ath Day	Year	3. Time of Death
-	Physici /Medi		Jerome	Joseph	Coleman,	Jr.					Dec	2	5	2007	4:10 P M
	Examir	er	4a. Facility Name	(If not institution	n, give street and nu	mber)		4b. Ci	ity, Town, o	or Location of	Death		4c. C	ounty of Death	
					1 Hospita			Ha	vre d	e Grac	e			Harfo	ord
	Funeral		5. Social Security	Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yr:	s. last birthda Vre		der 1 Year ns Days		Min. 8. (/	Date of Birth Month, Day, Year)  9. Birthplace (State or Foreit Country)			place (State or Foreign ptry)
	Director		215-92-5586 Vsual Residence of Decedent										1962	<u> </u>	id.
7	land		10a. State	10b. County		10c. 0	City, Town or	Location						1	Od. Inside City Limits
4	Marylar f show	ò	MD	Balı	imore	N	otting	ham							1 ☐ Yes 2 ☐ No
$\sigma$	th with the Maryla 23s or 28s-f shou	Director	10e. Street and N						Zip Code				10g. Citize	en of What Cour	ntry?
4:10 FM	3a or		2001 11		TIm i d	. #E		21	236				т.	J.S.A.	
	death	Funeral	11. Marital Status		ourt, Unit	edent Ever in	U.S. 13			Hispanic Origi an, Mexican,	in? (Specify	Yes or No		. Race - Americ	
	after or its	Ē	1 ⊋ Never Ma	rried 2 Mar	Armed For 1 ☐ Yes If Yes, Gi						Pueno Ricai	n, etc.)		Black, White,	
03	72 hours after death with the Maryland natural, or items 23a or 28a-f show Jigal Examiner must be notified at	1 by	3 Widowed	4 Divorced	Year or E	ates:		1 163	2∏ No	Specify:			3	Specify: Whit	ie
5	72 h	Completed	(Spi	15. Deceden	t's Education st grade completed)		(Gi	ve kind of	sual Occup work done	during most	of working		16b. Kind	d of Business/In	dustry
2	within ene. then	d d	Elementary/Sec	condary (0-12)	College (	1-4or 5+)	life	. DO NO1	Tuse retire	id)					
7	filed with Hygiene. other ther	S	12 17. Father's Name	- /First Middle	( and)		Carpe	nter		19 Mathar	's Name (Fir	nt Middle		structi	on
0	be fi	Be											, Maidell S	umamej	
5 \ 0	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, Ita M	2	Jen 19a. Informant's		Leman, Sr.		10h Ma	ilian Antala	/Ctuant		lae Wil		or Cityon	Town, State, Zip	Code
75/07 Maryland 21215-0036	s 1 and 2 should be filled within the flag of the than and the flag of the than other than other traumatic avent, its M					. h	1	-							) C00e)
		1.5	20a. Method of D		n, Sr./Fat		Place of Dis			t., No	Date	ialli,		21236 ation - City or To	own, State
	00		1 🗆 Burial	2 Cremation	3 □Removal from	State	cemetery, c	rematory c	or other pla	1					
12 Baltimore.	ritani ritani	3 4	4 Donation 21. Signature of I	n 5 ☐ Other (S		Ва	ıvview			12	2/07/20	007	Balti	lmore, M	ſd.
Ba	permit. Pag Department Important: f any Injury o		21. digitatoro di 1	7//						r Road				al Home	
			23a. Part1. Enter	r the disease, or	complications that	caused the de								Iu • 212	Approximate
1	<b>D</b>	ŀ	shock, or he Immediate Cause		only one cause on	each line.		101	1	-	L! 0				Interval Between Onset and Death
	Physician /Medical		disease or condit resulting in death	tion	a. Dua to	(or as a cons	ava	al	IVI	aru	100	)			LI WEEK
	Examiner					OKOO	aru	Ar	ter	V D	ison	se			
	1	je	Sequentially list of if any, leading to cause. Enter Und Cause (Disease)	conditions, immediate	b. Due to	(or as a cons	equence of):		1 01	7 =	1004.				
	ansign d	Examiner	Cause (Disease of that initiated ever	or injury	<b>S</b> .										
و لو	an aff	EX	resulting in death	n) Last	Due to	(or as a conse	equence of):								
MM68760.	tificate be executed og physician and as the burial-transit	edical			d										
	= 5 10		IF FEMALE:												
Sox Box	attendin	an/	23b. Was decede			birth 2 🗌 Fe	etal death		c pregnanc	у			23	3d. Date of deliv Month	ery Day Year
100	that the death cered by the attendired deteched for use	by Physician/N	1 ☐ Yes 2 9 ☐ Unknow	2 □No	4∐Preg 9⊟Unkr	nant at time of lown	f death 5	5 🗌 Other	(specify) _						
, ) a	hat it od by detec	Ph			ons contributing to d	leath but not r	esulting in the	underlyin	in cause di	ven in Part I.		23e. Did t	obacco us	e contribute to t	he cause of death?
C B	The law requires that the death cer lie has been signed by the attendir age 2 should be deteched for use	d by					<b>-</b>						Yes 2□		
Oleman Vital Records.	v requir been s should	Completed										24a. Was	-	Odb Mars aut	opsy findings available
E 3	has ne 2 s	E E									-	auto		prior to co	mpletion of cause of
$\mathcal{Q}_{\overline{u}}$			25. Was case ref	arrad to madian	1					00 51		1 Yes		1 ☐ Yes	2□No
		o Be	examiner?		Hospital:	npatient 2	☐ ER/Outpat	ient 3[7]	DOA Ott	han	of Death (Ch			Other (Special	6.1
3	Phys or this oral di	. To	27. Manner of De	other and the second		of Injury oth, Day Year)		of	28c. Inju Wo				how injury		(9)
0	nding F th. : After e funera	흝	1'Matural 2 ☐ Accident	5 Pendii invest	'9	ith, Day Year)	Injun	М		irk? ]Yes 2.∐N	lo				
) Division	or Attencater death Director: in by the	iii Ci	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	nined 200. Place	e of Injury - At ling, etc. (Spe	home, farm,	street, fac	tory, office	115	28f. I	Location (	Street and wn, State)	Number or Run	al Route Number,
	s afte	Certification:	4 1 1101111010		build	iiig, etc. (ope	city)					oy o	w, olate)		
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	cai	29a. Certifier (Check only	Cartifying Madical	ng Physician: To th Examiner: On the t	e best of my k	nowledge, de	ath occurr	red at the ti	ime, date and	d place, and o	due to the	cause(s) a	and manner as s	stated.
	the H in 24 the F nplete	Medicai	one)		and mar	ner stated.							Ú.		
	To To corr	2	29b. Signature	d title of certifie	r		991 34		24c. Licen:	se number	2	-		signed (Month,	
			1	will	ingl	X	1116		1)4	OUT		-	LEG	EMBER	206,2007
	1.		30 Name Ind ad	dress of person	who completed cau	se of death (if	m 23a) (Typ	e, Print)	Cin	cano	ak. I	) ~ "	Ral	A: ~ M	10 21014
	V (	ate	31. Date filed (M	onth, Day, Year	TRY I	Registrar's Sig	nature	JIVEK	UVIE	sayse	ure L	11;	DY	/TIV 19	U LIVIT
	Regist			EC 07	2007	فار استان	15 Ap	well	) ·						

DHMH 17 Rev 1/2001

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

À	1	-	For State Registrar		C	ertifi	cate of L	Death	F	Reg. No. 2	107	391			
. N	Physicia	-	1. Decedent's Name (First, Middle, Last)  Joseph			CAI	RACC	ī0	2. Date of Dea Month	Day	Year	39 time of De	eath M		
100	/Medic Examin	4	4a. Facility Name (If not institution, give str	reet and number)		4b.	City, Town, or	Location of Death	Decemb	4c. Coun					
AT S	LAGIIIII		THE JOHNS HOPKIN.	S HOSPI	TAL		ALTIM	-	TY		N/A				
*35	Funeral Director	- 1	5. Social Security Number 6. Sex 120-28-2969		in yrs. last birtho 68 Yrs	Mo	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	h y, <i>Year)</i> 3 1939	9. Birthplace (State or Foreign Country) MA					
	pu:		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Town o	r Locatio	n	<del></del>			1	10d. Inside City	Limits		
	faryla short ed at	ō	PA Buc	ks	•		Now	Норе	1 ☐Yes 2 ☐ No						
	the N 28a-	Funeral Director	10e. Street and Number	K3		10	Of. Zip Code	Порс		10g. Citizen of What Country?					
	h with	<u>a</u>	516 Waterford Cou	rt				18938		l	JSA				
	deat	ner	11. Marital Status	2. Was Decedent Eve Armed Forces?	er in U.S.	13. Was	Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bi	ace - Americ ack, White,				
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	:		∕es 2⊠No			Spec		White			
S O	72 hc 'natu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. D	ecedent's	dent's Usual Occupation kind of work done during most of working DO NOT use retired)			16b. Kind of	Business/Ind	dustry			
121	vithin ane. :han '	du	Elementary/Secondary (0-12)	College (1-4or 5+)	+)		Deputy Sheriff			law i	w Enforcement				
р Б	filed v Hygie ther i	ပ္ပို	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		ВСР	74 Cy - 511	18. Mother's Nam	e (First, Middle,						
an	o o o	To Be	Armand Carac	cio				Mary	Toma	aselli					
Maryland	2 should be and Mental is marked raumatic ev	-	19a. Informant's Name/Relationship (Type	e. Print)	19b. N	failing Ad	ddress (Street	and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip	Code)			
	1 and 2 Health a em 27 is		Loretta P. Caraccio	(spous				Court, I							
Baltimore,	Pages ient of int; If it iry or c		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of D cemetery, St. Joh			De 20	07 007	20c. Location	•				
Balti	permit. Departm Importa any Inju		21. Signatur of Funeral Service License	Ital	1	22. Na	me and Addres		Stallin d. Pasa	gs Fund dena. 1	eral H	lome, P.	.А,		
	26		23a. Part1. Enter the disease, or complications that caused the death. Poinot enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate Interval Betw. Onset and D												
*	Physician	Immediate Cause (Final disease or condition											eath RS		
	/Medical		resulting in death)  Due to (or as a consequence of):												
В	Examiner		Sequentially list conditions, b.	ASPIRA	TION		EUMO	NIA			;	5 HOU	RS_		
Sec.	ed sit	Examiner	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a c				. 4 1 8 /	.60		1	19 HOU!	RS		
9	xecut and al-tran	xan	Cause (Disease or injury that initiated events resulting in death) Last  C. UPPER GASTROINTESTINAL BLEED  Due to (or as a consequence of):									2			
68760,	e be e sician buria		L <sub>d</sub>												
68	tificate be executed ig physician and as the burial-transit	fedical										-			
Вох	th cer endin r use	an/IV	23b. was decedent pregnant	Bc. If yes, outcome pf 1 ☐ Live birth 2		3 □Ect	opic pregnancy	/			Date of deliv Month		ear		
В	uires that the death cer signed by the attendin d be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown		5 ☐ Otl	her (specify) _				VIOTAT	Day 10			
<u>ር</u>	d by t	Phy	Part II. Other significant conditions con	tributing to death but	not resulting in t	he under	lving cause giv	en in Part I.	23e. Did 1	tobacco use co	ontribute to	the cause of de	eath?		
rds,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed by							1 🗆	1 Yes 2 No 3 Probably 4 Unk			nknown		
or Vital Record	e 2 should	Completed	24a. Was an autopsy performed?								b. Were auto prior to co death?	opsy findings avoint of cau	vailable use of		
a	Ician: Th certificate ector, pag							00 Bloom (Do	1□ Yes	2 <b>23</b> ,No	1 ☐ Yes	2 <b>X</b> No			
₹	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner?	ospital:	2 ER/Outp	atient 3	BILDOA Oth	26. Place of Dea	ome 5 ☐ Res		Other (Spec	eifv)			
10	ding Physician: The lar n. After this certificate has funeral director, page 2	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Tir		28c. Injui Wot		28d. Describe						
ior	Attending r death. ector: Afte by the fune	atio	2 ☐ Accident investigation					Yes 2 □ No							
Division	al or Att	Certification:								(Street and Nu wn, State)	mber or Rui	ral Route Numb	er,		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Phys	Ician: To the best of ner: On the basis of e and manner state	examination and	death oc	curred at the ti tigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and , date and plac	manner as ce, and due	stated. to the cause(s)	)		
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licens			29d. Date sig					
	-		then, ME	DICAL DO	OCTOR		RES	-000		DECEM	BER 2	,200	7		
} '	5 Y		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (T	ype, Prin	nt)	OD NORTH	WOLFE	TREET. R.	ALTIMO	RE MD. 2	1287		
1.	)		MARKOS KASHIOURIS,	THE JOH NS  32. Pegistrar				, CO 140K1 K			1511/10				
	St: Regist	ate	31. Date filed (Worlin, Day, Tear)	#7.	La	Soci	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11.05 AM 2007 Ethel Μ. Dietz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital 9. Birthplace *(State or Foreign Country)* Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 22, 1922 5. Social Security Number 6. Sex **Funeral** Months Days Yrs. Director 213-12-6466 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Parkville Maryland Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with United States Of America 21234 8800 Old Harford Rd. Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes | 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home <u>Housewife</u> 10 of Health and Mental Hygid fitem 27 Is marked other Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, <u>i</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Sanft Hughes George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carroll Cr. Baldwin, Maryland 21013 4920 Charles R. Dietz Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State Dec. 8, 2007 Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn 21. Signature of Funeral Service Lic 22 Name and Address of Facility EVANS FUNERAL CHAPEL & CREMATION 8800 Harford Road Parkville Md., fatine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HYPERCAPNIC RESPIRATORY PALLARE days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes HEART FAILURE CONGESTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 2 2 No 2 🗖 № 1 ☐ Yes Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🛛 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Hospital or Attending (Month, Day Natural 5 ☐ Pending investigation Year) 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier tong ham Ker ooo Monanda 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I och Raven Blrd. FANCTHAM MONTHIDA 5601 . Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** Iris B. Ebberts 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F 218-05-4660 April 9, Director 1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location show 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Locust Drive Funeral 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White ۶ ک 3 Widowed 4 ☐ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within : Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "ray injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Bauernschmidt Laura E. Patt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary S. Coberth 407 Locust Drive; Catonsville, Maryland 21228
se of Disposition (Name of Date 20c. Location - City or Town, State Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park 12/6/2007 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Respiratory
Due to (or as a consequence 1): **Physician** disease or condition resulting in death) /Medical Examiner onaestive Sequentially list conditions, if any, leading to infine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Pericardia Due to (or as a consequence of) Pheumonia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an perform or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2M No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 03 2000 MD 2 e of death (Item 23a) (Type, Print) Agnes Hospital, 9005. Coton Ave. Baltmore 21229

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0

DECEMBER

Vital Records, P.O. Box 68760, Division or Hospital within 24 hours a

filled in by the funeral completely

> State Registrar

(Check only one)

29b. Signature and title of certifier

EDDIE NAKHUDA, M.D.

29d. Date signed (Month, Day, Year) 12.6.07.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARE

2300 DULANEY VALLEY ROAD

TIMONIUM 21093

31. Date filed (Month, Day, Year)
DEC 0 32. Registrar's Signature 2007

Registrar

DHMH 17 Rev 1/2001

State

<u>RICHARD LINTHICUM</u>

DEC 0

31. Date filed (Month, Day, Year)

ORIGINAL

7601 OSLER DRIVE TOWSON, MARYLAND 21204

M.D.

32. Aggistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** December 5, 2007 1:10PM Marvin David Fishler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Potomac Potomac Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Director 096-18-4542 80 May 22, 1927 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? "natural", or Items 23a or 217 Booth Street #314 20878 Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American India Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: 3 Widowed 4 □ Divorced WWII White Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Health and Mental Health and Mental Health and Mental Hem 27 is marked oth Be ဥ Jacob Fishler Sadie Zuckerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau Patricia Weiner/ Daughter 12613 Falconbridge Drive, Gaithersburg, Maryland20878 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Crematorium Inc. 6, 2007 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

M00335 Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee 23a. Part1. Enter the discase, or coor lice tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Generalized Deconditioning /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Pneumonia Due to (or as a consequence of): Physician/Medical Examiner Urosepsis burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Anemia the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed k I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pre Renal Azotemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Congestive Heart Failure page performed? Yes 2 No certificate Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2X No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 X Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medical 29a. Certifier 🛚 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D20274 December 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Boulevard, Bethesda, Maryland 20817 Kirti Vohra, M.D.31. Date filed (Month, Day, Year) Registrar's Signature State DEC 07 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per land /8374 12-7 07 Health and Mental Hygiene 39147 Reg. No 2 0 0 7 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year 2011 P.M **Physician** ressie TINGERMAN /Medical Town or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Examiner MI COLUMBIA 71 GENERAL HOSPITAL DWAKD If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** 1 M 2 D F Months Days Country) Hours Yrs. 132-12-7483 87 09/24/1920 Director NY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD HOWARD ELLICOTT CITY 1 ☐Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3004 N. RIDGE ROAD 21043 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAC0B SANDBERG ဂ DORA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 CYPRESS BAY COURT - ELLICOTT CITY, MD. 21042 CRAIG FINGERMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <del>11/</del>09/2007 ST. ALBANS, NY MONTEFIORE 21. Signature of Funeral Service\_Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ingestive Hear /Medical Dunlo (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?
1☐ Yes 2☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Inpatient 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No after death.

Director: A
d in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide within 24 hours at To the Funeral L Hospital Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 056854 30. Name and a sen-yho completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

			Plea					delible Ink				gible.			
		For State		St	ate of Ma	arylan		artment of F		Mental Hy	giene				
		Registrar					Се	rtificate of	Death		Reg. No. 2	007	39118		
Physicia	an 🐇	1. Decedent's Name		le, Last)		GRE	EEN			2. Date of Do Month	Day	Year	3. Time of Death		
/Medic		4a. Facility Name (/		n. <i>aiv</i> e street	and number)	0112			or Location of Dea	Iseremble 9 2007 8					
Examin	ier	North	WEST	HOSPI					allstow						
Funeral		5. Social Security N		6. Sex		e (In yrs. i	last birthday	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av. Year)	9. Birth	nplace (State or Foreign untry)		
Director		213-32-		1 M	ZX F	77_	Yrs.			11 0			MD		
land bw If		Usual Residence of 10a. State	10b. County	,		10c. City	y, Town or L	ocation					10d. Inside City Limits		
Mary Fishe	tor	MD	N	IA		E	Balti	more					<b>X</b> □Yes 2□No		
h the	Director	10e. Street and Nu						10f. Zip Code			10g. Citizen	of What Cou	untry?		
th wit	al D	2903 Boa	arman	Ave					21215		Ţ	J.S.A	S.A.		
tems tems	Funeral	11. Marital Status		A	as Decedent rmed Forces?		.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Pue	Specify Yes or North Rican, etc.)	0- 14. [	Race - Amer Black, White			
and 2 should be filed within 72 hours after death with the Maryland balth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show ler traumatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Marr 3 ☐ Widowed		ried 1	☐Yes 2☐ Yes, Give ear or Dates:	No		1 ☐ Yes 🔏 ☐ No	Specify:		Spe	ecify: B1	ack		
2 hou		A	15. Deceder	nt's Education	1		16a. Dec	edent's Usual Occup	pation		16b. Kind o	of Business/I	ndustry		
hin 7. e. an "n Medi	Completed	(Speci	ondary (0-12)		ollege (1-4or !	5+)	life.	e kind of work done DO NOT use retire	during most of word)	orking					
ygien ygien er tha	Con	l2th gra	ade		2yrs	,		Housewi	1			Home			
be file d oth even	Be	17. Father's Name		Last)						me (First, Middle Exum		,			
nould I Men narke	မ	Grant E					T 421 14 1		L						
d2sh thanc 7 is n traun		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,  Raymond Green-Son  8667 Winands Road, Randallstown													
Heal Heal tem 2		Raymond 20a. Method of Disp		n-Son		20b. P	Place of Disc	osition (Name of	i	Date		on - City or			
Pages 1 nent of H nt: if iter ny or ott		1 Burial 2			val from State			ematory or other pla		2/12/0	7 Owi:	nas M	Mills, Md		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu				100.		2. Name and Addre	ess of Facility						
S a m S		1/4	la	Ma	reh		4	larch F/ 300 Wab	n west ash Ave	, Balt	imore	, Md	21215		
		23a. P rt1. Enter t shock, or hea	the disease, o art failure. Lis	r completeliut t only one ca	hat cause use on each li	d the death ne.	h. Do not er	nter the mode of dyi	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between		
Physician		Immediate Cause disease or condition	(Final on	a.	Gasti	o int	estina	it bleed					Onset and Death		
/Medical Examiner		resulting in death)			Due to (or as	111	uence of):		·+2						
	-e-	Sequentially list conditions, if any, leading to intrinediate b. Castutis & Esophagitis  Due to (or as a consequence of).													
uted	Examin	Due to (or as a consequence of).  cause. Enter Underlying Cause (Disease or injury that initiated events  c.													
be executed cian and bunial-transit	Exa	resulting in death) Last Due to (or as a consequence of):													
	lical	d													
The law requires that the death certificate ite has been signed by the attending physinage 2 should be detached for use as the	Med	IF FEMALE: 23c. If yes, outcome pf pregnancy									- 1	-			
eath c attend for us	ian,	23b. Was deceden	months?	1	Live birth	2 🗆 Feta	death 3	□Ectopic pregnanc	у		23d.	Date of deli Month	very Day Year		
the d	Physician/M	1 ☐ Yes 2 € 9 ☐ Unknown			Unknown	t time or a	leatii 5								
w requires that the d been signed by the should be detached	by P	Part II. Other signi	ficant condit	ions contribu	ting to death b	out not resu	ulting in the	underlying cause give	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?		
equire en sig ould b	ed b	- Ischen	uce los	utis,	Card	ionu	yopa	Thy ; Ken	al	. 10	Yes 2□N	lo 3□Pr	obably 4 driknown		
law re as be 2 sho	Completed	Failer	le , 1	H4P0	tensit	n				24a. Wa	s an 2		topsy findings available completion of cause of		
	Com			01						per	formed? 2 No	death? 1 ☐ Yes			
sician: Th certificate rector, pag	Be	25. Was case referexaminer?	rred to medica		tal			10"		eath (Check only	one)				
G io. ✓	2	1 Yes 2		Hospi	a. Date of Inju		ER/Outpatie	all S DOA		Home 5 □ Res			cify)		
ding h. After fune	tion	1 ☑ Natural 2 ☐ Accident	5 Pendi		(Month, Da	y Year)	Injury	Wo	iryat ork? ]Yes 2∐No	260. Describe	how injury oc	curred			
or Attending Physician: ther death. Director: After this certifica in by the funeral director, i	fica	3 ☐ Suicide 4 ☐ Homicide	6 Could	not be				treet, factory, office		28f. Location	(Street and N	umber or Ru	ıral Route Number,		
s after at Dire	Certification:	4   Homicide			building, e	tc. (Specin	y)			City or 10	own, State)				
To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only	1 ⊈ Certifyi 2 ☐ Medica	ng Physicia I Examiner:	n: To the best On the basis o	of my kno	wledge, dea	ath occurred at the t	ime, date and plac	ce, and due to the	e cause(s) and	d manner as	stated.		
the H hin 24 the F the F	Medical	one)			and manner st										
7 Wit	-	29b. Signature and title of certifier  A. Lucyllaceum, MD							29c. License number 29d. Date signed (Month, Day, Year, De Ceurber, 4, 20						
					/ / /	looth /lto-	n 22n\ (T								
5		30. Name and add	H H 2	Frou	Ned cause of c	ream (Item	101 D	Id Court	Road, 1	Randalls	TOWN ,	MD	2/133		
Sta	ite	31. Date filed (Mor		2	32 regist	rar's Signa	ature -	1-10-							
Registr	rar		DEC 0	7 2007	Jan Lo	W 1	S FA								

Registrar DHMH 17 Rev 1/2001

State

2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

30. Name and address of person who

Walthern

completed cause of death (Item 23a) (Tyge, Print)

Woods

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25at per Maryland / Department Bealth and Mental Hygiene Certificate of Death Red. No. Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11=07 PM **Physician** Wilma Garner December J. 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hapkins Rayview Medical Center Pattimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1 Under 1 Year | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 T F June 8, Maryland 213-52-3433 1949 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b County 10a State 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 TNo Maryland Dundalk Directo Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 210 Cleveland Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: White Ş 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) marked other than Elementary/Secondary (0-12) Own Home Housewife 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be fill int of Health and Mental Ht. If item 27 is marked oth Myrtle Lawson Alvin Smith Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1647 Hillwood Drive Apt G7, Knoxville, Tenn 37920 Daughter Tina Parker Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Bayview Crematory Baltimore City, MD. 4, 2007 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 ign-ture of Funeral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory 30 minutes **Physician** Failure /Medical Due to (or as a consequence of): Examiner 4 days Muttilobar Preumenio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 days Due to (or as a consequence of) Examine Aspiration Pneumonia the burial-transit The law requires that the death certificate be executed and l Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical as 1 attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the s 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy page 2 performed 2 No Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Iniury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1 24 hours a 1 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 DECEMBES 2,2601

State

Registrar

31. Date filed (Month, Day, Year)

Jenniter Cheng



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Butimire MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per dr., g874612407497dhbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 19:00 PM William J. Glenn, Sr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel If Under 1 l Air, Maryland 1 Year | If Under 24 Hrs. | 8, 1 Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 04/23/1940 **Funeral** Days Months Hours 1 ★M 2 ☐ F 67 **Director** 212-36-9707 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "natural", or items 23a or the Medical Examiner must be 1707 Chatsworth Court 21047 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law\_Enforcement 12 Policeman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ 1 and 2 should be Health and Mental မ William Earl Glenn Catherine Hasenei 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and z . tment of Health a Department of Health Important: If Item 27 any Injury or other tr Wendy J. Glenn (daughter) 3113 Deer Creek Drive - Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Highview Memorial Gdns 11/29/2007 Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. asseln 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical **Examiner** BLADDER CANCER Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last METASTASIS Exami burial-trar physician s the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe Vital 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) Manner of Death

Natural

Colored 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Hospital or Attending Division 1 ☐ Yes 2 ☐ No hours after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D0063220 GEORGE ISCHARMS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 MPFR CHESAPEAKE

Registrar

State

31. Date filed (Month, Day, Year)

DEC 0 7

483021

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Harry Charles Glover Sr. 3, 2007 22:05 /Medical December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2 □ F 79 5, Director Sep. 1928 Pennsylvania 199-22-7111 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or Items 23a or 28a-f show 10a State 10h County 10c. City, Town or Location th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ XIo Director Maryland Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Chell Road 21085 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 🐉 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Industrial Chemical Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental Int. If Item 27 Is marked or Joshua (nmn) Glover Emilie Wilson Sharpe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 I any injury or other tra once. Vivian J. Glover / Wife 213 Chell Road, Joppatowne, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 12-6-07 Towson, Maryland niture of Funeral Service Licensee 22. Name and Address of Facility.
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 15m Hbdomina /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Yes 2. No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in True Control of the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2. To the I 29b. Signat and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12-4-200 B6532737

State

Registrar

31. Date filed (Month, Day, Year)

520 upper Chesapaake Drive Bel-

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:110 AM WILSON CALEB GEBHARD DECEMBER 200 4c. County of Death 0 iverside If Under 24 Hrs. cam If Under 1 Year Birthplace (State or Foreign Country) Months Days Hours Min. **M** M 2 □ F 169-26-0258 75 1932 Mar. Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at

**Physician** 

/Medical

Examiner

**Funeral** 

Director

**Physician** /Medical Examiner

attending physician for use as the buria detached within 24 hours after death To the Funeral Director:

the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Funeral D	339 South Deen Ave.	21001					USA					
unei	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whi					
Y F	1 ☐ Never Married 2 【文 Married 1 ☐ Yes 2 【 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		⊒Yes ≱⊉No				Specify:	1 L-				
Be Completed by		. Decede	nt's Usual Occup	ation		16b.	Kind of Business	hite /Industry				
plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give ki life. D(	nd of work done O NOT use retired	during most of workird)	ng							
E		uck_	Driver			Cc	ncrete (	Company				
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	e, Maiden Surname)						
0	Unknown Unknown Gebhard			Lizzie								
			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Elizabeth L. Gebhard / Wife 3	39 S	outh Dec	n Ave., A	berdeer		Maryland Location - City or					
	1 Bullar 2 Acternation 3 Ameritoval Iron State	ry, crema	tion (Name of atory or other plac	ce)	ate	20¢.	Location - City of	Town, State				
	4 □ Donation 5 □ Other (Specify) Hillto	op S	ervice C	om 12-5	<del>-</del> 07	To	wson, Ma	ryland				
	2 resonaure of Purieral Service Licensee			inerally Hom			65507075					
_	23a. Part1. Enter the lease, or complications that caused the death. Do shock, or heart in re. List only one cau e on each line.	not enter	the mode of dvir	bury Road	r respiratory a	Idor rrest.	n, Maryl	and 21009 Approximate				
	shock, or heart to re. List only one cau e on each line.  Immediate Cause (Final	1		1	1	,,,,,		Interval Between Onset and Death				
	disease or condition resulting in death)  a. Due to (or as a consequence	MJ T	ic/06	teomyeli	tis							
		01/.	/	/								
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):										
Ē	that initiated events											
Ĕ	resulting in death) Last Due to (or as a consequence	of):										
Ica	d											
Me	IF FEMALE:											
ian	23b. Was decedent pregnant in the past 12 months?		ctopic pregnancy	/		1	23d. Date of de Month	livery Day Year				
Physician/Medical Examiner	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5∐(	Other <i>(specify)</i> _					,				
	Part II. Other significant conditions contributing to death but not resulting in	n the und	erlying cause giv	en in Part I.	23e. Did t	obacco	use contribute t	o the cause of death?				
pleted by	Peripheral Vascular	Di	CAG CA		1 🗆 '	Yes	2 <u>₽</u> ¶0 3□P	robably 4 Unknown				
ete	Illiand David + =	,	2000		24a. Was	an	24b Were a	utopsy findings available				
E O E	Advanced rements				auto; perfo	osy irmed?	death?	utopsy findings available completion of cause of				
De C	25. Was case referred to medical			26. Place of Death	(Check only o	2 1	√o 1 □ Ye:	s 2□46				
0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient	3 DOA Oth	er: 4 Dayursing Hon			6 ∏Other (Soe	ecify)				
		Time of	28c. Injur Wor	y at 2	28d. Describe			,)				
cation:	2 Accident investigation	,,		Yes 2 □ No								
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)	rm, stree	et, factory, office	2	28f. Location (3 City or To	Street a	and Number or Fi ite)	ural Route Number,				
S												
edical	29a. Certifier  (Check only one)  One)  20 Medical Examiner: On the basis of examination ar and manner stated.	), death o	occurred at the tirestigation, in my o	me, date and place, a ppinion, death occurre	and due to the ed at the time,	date a	(s) and manner a and place, and du	s stated. e to the cause(s)				
Me	29b. Signature and title of certifier	29c. License number				29d. Date signed (Month, Day, Year)						
							1					

State

Registrar

30. Name and address of person who completed cause of dear (Item 23a) (Type, Print)

DEC 0

07-09400 Jar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 39154

		For State Of Maryland / Department of Fleath and Wich	Reg. No.	
Physician/	1.	oistrar Decedent's Name (First, Middle,Last)  JANE MICHELLE HILL	2. Date of Death  Month Day  December 4, 2007	3. Time of Death Year 1454 hrs
lical Examiner		a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location		nty of Death
	L	Johns Hopkins Hospital Baltimore  7 Ane (In vrs. last birthday) If Under 1 Year   If	er 24Hrs. 8. Date of Birth(MM/DD/Y	YYY) 9. Birthplace (State or
Funeral Director	5.	Social Security Number  6. Sex 7. Age (In yrs. last birthday) Age (In yrs. last birthd		Foreign Country) MD
any	_	sual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
		MD N/A BALTIMORE CITY		1 X Yes 2 No
the Maryland or 28a-f show lifted at once.  Director	10	0e. Street and Number 10f. Zip Code		of What Country?
th the Maryland 23a or 28a-f sho notified at once.		2901 OAKHILL AVENUE 21207  1 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	US	A Race - American Indian, Black,
or items 23	1	1 To Never Married 2 Married Armed Forces?  If Yes, specify Cuban, Mexica	n, Puerto Rican, etc.)	White, etc.
fler der l'r, or i	, I	Widowed 4 Divorced If Yes 2 X No specification or Dates:		of Business (Industry
nours after an antural" (xamine)		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give during most of working life. DO NO		of Business/Industry
ed within 72 hour siggiene. other than "natu he Medical Exan	2	College (1-4 or 5+)  9  UNEMPLOYED		
be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f shert, the Medical Examiner must be notified at once Be Completed by Funeral Director	3 1	17. Fathers Name (First, Middle, Last)	er's Name (First, Middle, Maiden Surr	
Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Itant: If item 27 is marked other than or other traumatic event, the Medical To Re Comple		JAMES W. HILL M.  19a. Informant's Name/Relationship (Type, Print ). 19b. Mailing Address (Street and No.	ARY M. WILLIAM imber or Rural Route Number, City of	S r Town, State, Zip Code)
id 2 should hith and Me m 27 is ma aumatic ev	- 1	ROCHELLE L HARGROVE/ DAUGHTER 2414 ANNOR	COURT, BALTIMO	ORE, MD 21230
es 1 and 2 sho of Health and If item 27 is ther traumati	1/2	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Loca	ation - City or Town, State
permit Pages 1 ar Department of He Important: If ite	1	4 Donation 5 Other Specify:		
permit. Page Department o Important: injury or oth	1	21. Signature of Funeral Service Licensee 22. Name and Address of Fac	HOWELL FUNER Y HEIGHTS AVE	RAL HOME 2120
Physician	4	20a. P. I. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such a	cardiac or respiratory arrest, shock,	or heart Approximate Inter Between Onset a
1edical_		To rediate Cause (Final disease a. Methadone intoxication		Death
aminer		or condition resulting in death)  Due to (or as a consequence of):		
a	<u>.</u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		
,	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):		
nd nd ransit		events resulting in death) Last d.		
60,  Ite be executed hysician and e burial - transit	gig	X UNPENDED AMENDED AMENDED 4.27,28a-f, perME,g874, 12/24/07 T	23d	Date of delivery
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be cleached for use as the burial - transi	Physician/Medical			onth Day Year
SOX 68 / 6 death certificate e attending phy I for use as the b	Sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 V Unknown		
the dea		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		e contribute to the cause of death?
ires that the de signed by the	[조		1 Yes 2 1	No 3 Probably 4 V Unknow
rds, requir been s	Completed		24a, Was an autopsy	24b. Were autopsy findings avail prior to completion of cause death?
eco he law ate has	gmo		performed? 1 ✓ Yes 2 No	1 Yes 2 No
al K	Bec	25. Was case referred to medical	ath (Check only one)  Nursing Home 5 Residen	ce 6 Other:
F Vit	2	1 ✓ Yes 2 No		
ading th.	io.	1 Natural 5 Pending Fnd 12/4/2007 unk		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death.  "Il Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ficat	28e. Place of Injury - At home, farm, street, factory, office building		d Number or Rural Route Number, e St. Baltimore, MD
Div pital o ours aft eral D	Certification:	determined (Specify) found at home		
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea	d place, and due to the cause(s) and h occurred at the time, date and plac	ce, and due to the cause(s)
To the within To the comp	Medical	and manner stated.  29b. Signature and title of certifier  29c. License nur		Date signed (Month, Day, Year)
		O.C.M.E	Dece	ember 5, 2007
		30. Name and address of person who completed cause of death (Item 23a)	ro MD 21201	
Ø		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimo	TE, IVID Z 1201	
Sta Regist	ate	The Congression		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Keith Hanson, Sr. 1- For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 30, 2007 1705 hrs Medical Examiner <u>Keith Antonio Hanson</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2501 Violet Avenue 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Maryland Country) Days Hours Months 195 Director 214-82-8238 Nov. 2, 1X M Usual Residence of Decedent 10d. Inside City Limits 10c City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show N/A Maryland Baltimore hours after death with the Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 2501 Violet Avenue #702 21215 USA 14. Race - American Indian. Black. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 1X Yes <sub>Specify</sub>Black Yes 2 X No specify: If Yes, Give Year Widowed 4 Divorced 6 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "r d other than ", the Medical F Baltimore, MD 21215-0036 10th grade Self-Employed Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lula Williams James Hanson Be or other traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Cockeysville, Md 21030 Crosswinds Place Laurie Hanson/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) Cremation 12/8/07 Dundalk, Maryland Trinity Cemetery Donation 5 Other Specify 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, Md of I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and ailure. List only one cause on each line /Medical

xaminer

certificate has

and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760, page 2 this After e Hosping.

n 24 hours after death.

he Funeral Director: A within 7

Be

Certification:

Medical

State Registra

2

3

(Check only

25. Was case referred to medical

5 Pending

6 X Could not be

Investigation

30. Name and address of person who completed cause of death (Item 23a)

Hospital:

Inpatient

Fnd 11/30/2007

28a. Date of Injury (Month, Day, Year)

(Specify) House

Assistant Medical Examiner

32 Registrar's Signature

and manner stated

examiner?

1 V Yes

27. Manner of Death

Natural

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Month, Day, Year)

le

-	Immediate Cause (Final disease a	Acthadone intexication				
	or condition resulting in death)	Due to (or as a consequence of):				
I Examiner	cause. Enter Underlying Cause	Due to (or as a consequence of):  Due to (or as a consequence of):				
dica	X UNPENDED	#25a,27,28a-f, perME,g876, 2/20/08 TT				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  4 Pregnant at time of death  5 Other (Specify)		23d. Date Month	of delivery Day	Year
ģ	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the ca	ause of death?
Completed			24a. Was an autopsy performe	ed?		findings available etion of cause of
$\ddot{\circ}$						

ER/Outpatient 3

28b. Time of Injury

Fnd 5;00 pm

28e. Place of Injury - At home, farm, street, factory, office building, etc.

ORIGINAL

28d. Describe how injury occurred

or Town, State) 2501 Violet

26. Place of Death (Check only one

Nursing Home 5

unk

Other<sub>4</sub>

1 Yes 2 y No

28c. Injury at Work?

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Residence 6 V Other: Scene

28f. Location (Street and Number or Rural Route Number, City

December 1, 2007

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 /Medical 4b. City, 4a. Facility Name (If not Institution, give street and number) Town, or Location of Death 4c. County of Death Examiner andtown more 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1□M 2**Ø**F Months Days Hours Min Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 271s marked other than "natural" no ther trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marijal Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 26 DO Maiden Surnar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Be 19 he 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 19a. Informant's Name/Relationship (Type. Print) 3600 Balto. W tranklin 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 20c. Location - City of Town, State 1 M Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5 1 M 2222 W. NOY th 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or s a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Division or Vital Records, P.O. Box 68760. physician for use as IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by the funeral director, page 2 should be 1 🗌 Yes 2 🗆 No 3 Probably 4 1 Hiknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 1□ Yes 25. Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Urrsing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 1 Inpatient 2 ER/Outpatient 3 □ DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of perso who completed cause of d th (Item 23a) (Type, Print) 1

Registrar
DHMH 17 Rev 1/2001

State

Day,

DEC 0 7 2007

Registrar's Signatu

7-09343		Please Type or Print in Black Indelible Ink. Ensure All Copie		ble.	
ugenio Harrison		State of Maryland / Department of Health and Mental Hy	ygiene		
	F	Registrar Certificate of Death	Reg.	No. 200	7 39 5
Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month December 2	Day Year	3. Time of Death 1610 hrs
Medical Examir		Eugenso Harrison			
		4a. Facility Name (if not Institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Deat	n
		Sinai Hospital Baltimore		<u> </u>	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min	_	(MM/DD/YYYY) 9. Bi Forei	rthplace (State or
Director		220-21-7053 1 M $2 - F$   $9$ Yrs.   Months   Days   Hours   Min	July		ountry)
	t	Usual Residence of Decedent		)	
any	Γ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd show	-	MD Baltimore			1 Yes 2 No
te Maryland or 28a-f show fied at once.	뚨	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	intry?
death with the Maryland or items 33a or 28a-f sho must be notified at once	Director	2515 Flannary lane 21217	'	118	A I
ath with the items 23a		11. Magital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( S	pecify Yes or No-	14. Race - Ame	rican Indian, Black,
item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	. 1
i, or		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 V No specify:		Specify: B	Jack 1
urs af	화	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business	/Industry
2 ho	흙	Elementary/Secondary (0-12) College (1-4 or 5+)	les ver	N. 1	0
hin 7	힐	12   Student/V	Vorked	171	U
21215-0036  Jeffed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
1215 Id be file Aental Hi narked o	Be	Eugene Harrison Lat	anva	John	SOD
Z = 8 = 5	٥	19a. Informant' None/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or	Rural Ro, e Numb	er, City or Town, Stat	
MD 12 sho th and 127 is	7	Ms. Latanua Potts 3505 Flannery	Lane P	Salto . N	10 21207
	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City of	r Town, State
Ore ges 1 t of F : If i		1 V Burial 2 Cremation 3 Removal from State crematory or other place)	lula 1	Lansdo	wne, MD
ti. Pa tmen trant	-	4 Donation 5 Other Specify: Mt, Zion Climetery 12	111101		
Baltimore permit. Pages 1.8 Department of Hi Important: If it		21. Signature of Funeral Service Lice ree 22. Name and Address of Fay fity.	Funezas	Home, P.	A. MA DIDY
	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arres	BAITO	MO DIQIC Approximate Interval
Physician /Medical		failure. List only one cause on each line.	or respiratory arres	st, shock, or near	Between Onset and
xaminer	ı	Immediate Cause (Final disease a. Gunshot Wound to Back			Death
`		or condition resulting in death)  Due to (or as a consequence of):			
	<u>,  </u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			
	اڃّ	couse. Enter Underlyin, Couse			
* -	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
executed)	빏	d			
	g	UNPENDED AMENDED			
760, ficate be g physicia the buria	ĕ	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery
× 687 h certific tending p	a l	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregn	nancy	Month	Day Year
ath ce attend or use	<u>[S</u>	4 Pregnant at time of death 5 Other (Specify)			
BO) le deat	Physician/Med	9 Officioni	One Did to		to the cause of death?
that the	힏	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			obably 4 Unknown
b, P.C	힣				
ords,	삘		24a. Was a autops		autopsy findings available completion of cause of
e law te has	Completed		perform 1 <b>V</b> Yes 2	ned? death?	
tal Rection: The certificate ector, page		25. Was case referred to medical 26.Place of Death (Check	1		100 2
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicially filled in by the funeral director, page 2 should be detached for use as the burinely filled in by the funeral director, page 2 should be detached for use as the buriness.	8	examiner? Hospital: 4 Inspired 2 of ED/Outpatient 3 DOA Other, Nurs		Residence 6 Oth	ner:
Physer thi	۵	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work?		ow injury occurred	
on of tending Pheath.	<u></u>	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 ✓ No	Subject shot		
Sio Atten deat cctor	ä⊟	2 Accident Investigation Dec 2, 2007 1555 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (St	treet and Number of I	Rural Route Number, City
Divisior ospital or Attend hours after death increal Director:	Certification:	3 Suicide b Could not be		ate) rest Park Drive, Ba	
Spital spours a neral I		4 Monicide			
To the Hos within 24 ho To the Fun completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cause Lat the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within 2 To the complet	ed.	and manner stated.			
	2	29b. Signature and title of certifier  29c. License number		29d. Date signed (A	
		arde Hallac O.C.M.E.		December 3, 2	UU <i>1</i>
$\overline{}$	l	30. Name and address of person who completed cause of death (Item 23a)			
$\sigma$		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist	rar	DEC 0 7 2007   Blesur D. Apara			
DHMH 17 Rev 1/20	001	OCME ORIGINAL			

07-09256 George Hicks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 39158

Jige			1- For State	Otato or i	,		cate of l	Death					eg. No.		UU		
	Physicia		Registrar  1. Decedent's Name (First,	Middle,Last)		-						Date of Dea Month		Year		ime of Death 847 hrs	
	Exami		George		cks							Month Novembe		007 County of			
			4a. Facility Name (if not ins				4b	Glen Bu		cation of l	Jeath		1	nne Arui			
			Baltimore Washin					If Under		If Under 2	24Hre T	8. Date of B	irth/MM/D	D/YYYY)	9. Birthpla	ce (State or	
	uneral	-	5. Social Security Number	6. Sex	7. Ag	e (In yrs. last b		Months	Days	Hours	Min.				Foreign	) MD	
D	irector		216-20-5821	1 X M	2 F	8	}() Yrs.					02/1	<u>6/192</u>	2/		/ IND	-
	<b>λ</b> :		Usual Residence of Deceded			10c. City, Tov	vn or Locatio	n							100	l. Inside City Li	mits
	w any			nne Aru	ndol	,,,			Ralit	timor					1	Yes 2 X	No
	Maryland 28a-f show d at once.	tor	10e. Street and Number	Tille Al a	nue i	<u> </u>		10f. Zip C		CLINOI	<u> </u>		10g. Citiz	en of Wha	at Country		
	Mar r 28a ied at	Director	6700 Ft. Sm	allwood	Dood					2122	6	1		US	A		ľ
	vith the Maryland ; 23a or 28a-f show ; notified at once.	al D	11. Marital Status		. Was Deceden	t Ever in U.S.	13. Was	Decedent	of Hispa	anic Origin	1? (Spe	cify Yes or N	10-	14. Race -	American	Indian, Black,	
	ath w items ist be	Funeral	1 Never Married 2	∨ Married	Armed Forces		If Ye	s, specify	Cuban, I	Mexican, I	Puerto R	tican, etc.)		White,	Whi	to	Ì
	ter de ", or er m	년	3 Widowed 4	Divorced If Yo				Yes 2 X						Specify:			
	ours a atural	d by	15. Decedent's Education	(Specify only h	ighest grade co		a. Decedent	's Usual O	ccupation	on (Give ki DO NOT u	nd of wo	ork done ed)	16b. K	and of Bus	iness/Indu	stry	
"	72 hc in "ni cal Ex	ompleted	Elementary/Secondary	0-12)	College (1-4 or	5+)	9	Condu	o+ ox	•			D-	ailro	ad		
03	within iene. er the	g mg	11					Jonau	11	8.Mother's	Name (	First, Middle					
5-	filed Hyg	ပ္ခဲ့	17. Father's Name (First, M George		cks				1	Ett		Bos					
21215-0036	denta Menta narke	o Be	19a. Informant's Name/Re		, Print )		19b. Mailing										
MD 2	2 should be filed within 72 hours after death with the Maryland hand Menlal Hygener and shearland, or items 23a or 28a-f sho grī is marked other than "natural", or items 23a or 28a-f sho mantie event, the Medical Examiner must be notified at once.	-	Marie S. Hi	cks	(spous						d Ro	oad, B	altin	nore,	MD 2	1226	
,e	2 = = =	- 3	20a. Method of Disposition				ce of Dispos matory or oth	ition (Name	e of cem	etery,	Dec	. 03	20c.	Location -	City or To	wn, State	
Baltimore,	ages l nt of l nt: If other		1 Burial 2 X Cre		Removal from S		o Crem		In	С.	2	007	Ba	ltimo	ore,	MD	
Ē	artme	1.0	4 Donation 5 Of 21. Signature of Funeral S	ervice Licen	-11	1		lame and A			,					ome, P.	Α.
ñ	Dep Dep	1	Muschel	U Sta	lle	AS)	F	3111	Mou	ntair	Ro	ad, Pa	sade	na. N	1D 21	122 Approximate In	terval
	ysician		23a. Fart I. Enter the dise failure. List only one	cause on each	line.						ardiac or	respiratory	arrest, sm	JCK, OI HE	ant	Between Onse Death	
F	<b>ル</b> dical xaminer		Immediate Cause (Final c	isease a. Hy	pertensive /		otic Cardi	iovascul	ar Dis	ease	_				- +		
			or condition resulting in d		e to (or as a con	sequence of):											
		ē	Sequentially list condition if any, leading to immedia	te Du	e to (or as a con	sequence of):											ŀ
		Examiner	cause. Enter Underlying (Disease or injury that ini-	intod C.	e to (or as a cor	coguence of):				_							
	ecuted and transit	EX	events resulting in death)	Last d.	e to (or as a cor	isequence or,											
		1 1	UNPENDED		AMENDED										ļ		
60,	cate be ex-	Medical	IF FEMALE:		23c. If yes, outo	come of pregna	ancy	_					23	3d. Date o		Va	
	rtifica ling p			ant in the	1 Live birth	at time of deat		etal death		Ectopio	c pregna	ancy		Month	Da	y Ye	31
Box 687	Attenting Physician: The law requires that the death certific death. After this certificate has been signed by the attending It, whe funded director nace 2 should be detached for use as It.	Physician/	1 Yes 2 No 9	Unknown	9 Unknown		<sup>tn</sup> 5 0	ther (Spec	city) _								
	the de		Part II. Other significant				sulting in the	underlying	cause g	given in Pa	art I.					e cause of dea	
P.0	ires that the signed by 1	2	end-stage rena									1	Yes 2			bly 4 🗸 Unk	
	v require s been si	Completed											Vas an utopsy	24b.	Were auto prior to co	ppsy findings av mpletion of cau	vailable use of
202	law r has b				····								erformed es 2		death?	2	No
Re	certificate has	<u></u>	25. Was case referred to	modical					26.Place	e of Death	(Check						
<u>+</u>	ysician: The last certificate director page	8	examiner?	Hos	spital: 1 Inpa	atient 2 🗸	ER/Outpatier	nt 3 🔲 🛭	OOA	Other 4	Nursii	ng Home 5	Resid	dence 6	Other		
> _	ling Physi After this	ਭੂ  ⊢	27 Manner of Death	No	28a, Date of	Injury	28b. Time of		28c. Inju	ıry at Wor	k?	28d. Desc	ribe how i	njury occu	rred	-	
u.	nding th.		1 🗸 Natural 5	Pending	(Month, Da	ay, rear)			1	Yes 2	No			_			
Division of Vital Records.		Cortification:	2 Accident 3 Suicide 6	Investigation Could not be	28e Place o	f Injury - At ho	me, farm, str	eet, factory	, office	building, e	etc.		on (Stree	and Num	ber or Rur	al Route Numb	er, City
ć	ital o urs afi ral D	t t	4 Homicide	determined	(Specify)												
	To the Hospital or within 24 hours after To the Funeral Di	>	793. Cellilei 4	ifying Physician	n: To the best o	f my knowledg	e, death occ	urred at the	e time, d	date and p	lace, an	d due to the at the time.	cause(s) date and i	and mann place, and	er as state I due to the	d. cause(s)	
	Fo the vithin Fo the	completely	KI		On the basis of eand manner stat	examination an ed	u/or investig			se numbe			29	d. Date sic	ned (Mor	th, Day, Year)	
	7	84	29b. Signature and title	of certifier				29		.M.E.	•		- 1		er 1, 200	_	
-	T		Janua 90	uthall.	(100)												
10	1		30. Name and address of	f person who co	mpleted cause Assistant M	of death (Item	<sup>23a)</sup> miner 1	11 Penr	Stree	et, Balti	more,	MD 2120	1				
10		0	Pamela E. Sou		497	strar's Signatu		and the	,								
		Sta	e 31. Date filed (Month, D	" " 7 21	107	and I	U K	1									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** December 2, 7:10 P M Pauline L. Hanley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hyattsville Sacred Heart Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F November 16, 1915 Washington, DC **Director** 578-05-3255 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show th and Mental Hygiene. 7 is marked other than "natural", or liems 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 USA 5805 Queens Chapel Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No White Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Cecil Charles E. Leyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 15718 Bond Mill Rd., Laurel, Maryland 20707 Mary Goggin- daughter Injury or other If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 5 ☐ Other (Specify) St. Mary's Cath. Cemetery 12/06/2007 Laurel, Maryland 4 □ Donation 22. Name and Address of Facility
Fleck Funeral Home, INC. 21. Signature of Funeral Service Licensee MO1234 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstructive Pulmonary Disease Immediate Cause (Final hronic **Physician** In Known disease or conditi resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 MNo
9 Unknown Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2/L/No 1∐ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours after to Funeral Dire bletely filled in b after **Dire** 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Function

completely 1 (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 143121 30. Name and address of person who completed odse of death (Item 23a) (Type, Print)

NURUL CHOWDHURY, MD; 15216 DINU DRIVE; BURTONSVILLE, MD 20866 31. Date filed (Month, Day, Year) State DEC 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month ero 21 Novembe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15 0 Tren OPL If Under 24 Hrs If Under 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 **3**-M 2 □ F Months Director unknown irginia Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County Show 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Director 1 Wes 2 No timbre 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If them 27 is marked other any injury or other? 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 2 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Be Ksor မ 0 ac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anderson harlo7 20a. Method of Disposition 20c Location - City or Town State 1 ☐ Burial 2 ☐ Oremation 3 □Removal from State 4 Donation 5 Dother (Specify) 1-2007 21. Signature of Funeral Service Licensee arly 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Levos **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-tran that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe No No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation Hospital or Attending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

State Registrar

(Check only one)

29b. Signature and title of certifier

MAROL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Catherine O. Jayroe 11-30-2007 6:40 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hosptial Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

88 Yre Months Days Hours Min. 8. Date of Birth Month, Day Year 04-05-1919 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 1 F 88 Maryland **Director** 212-12-6703 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 is marked other than "naturel", or items 23s or 28s-f ehow treumstic event, the Macilcal Examinar must be notified at 1 Yes 2 X No Maryland Harford Edgewood Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1802 Larch Dr 21040 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 五 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Defense Contractor 12 Inspector permit. Pages 1 and 2 should be fit.
Depertment of Health and Mental Hy,
Important: if item 27 is marked
eny injury or other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Cobel Herman Oliff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 626 Boxelder Dr Edgewood, MD 21040 David Jayroe (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12-07-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Securitally "It conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physicien and of the burial-transit The law requires that the death certificate be executed g/ resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year signed by the atte 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No Division of Vital ; After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Medical Certification; 5 Pending investigation s efter de... 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel or within 24 hours a To the Funerel C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Belair, MD 1 10 Khader Chesapeake Dr. 500 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 07 2000 2007 Registrar

ayroc

			1 - State Registrar	State of f	Marylan				ealth ar Death	nd Me	ental H	lygie Reg.	611	07	39	162
N.S.	C * 1 1 1		Decedent's Name (First, Middle, Last)							1	2. Date of	Death			3. Time of	Death
	Physici		CLEOLA VIRGINIA	JOHNS	ON						Month ECEME		Day Y 3, 200	ear 7	4:30	7) M
)	/Medic Examin		4a. Facility Name (If not institution, give :				4b. City,	Town, or	Location of I			71.11.5	4c. County of		1 4.50	А
- 10			Sunbridge Care (	enter			Elk	ton					Cecil			
1	Funeral	535	Social Security Number 6. Sex		Age (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under 24 Hours	4 Hrs. 8	3. Date of (Month,	Birth Day Ye	aar) g	. Birthp	lace (State o	r Foreign
¥.	Director		219-05-3235	M 2 DXF	88	3 Yrs.	MOTORIS	Duys	110013		May 1		1919		yland	
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation							11	0d. Inside Ci	ty Limite
	sho	'n				•	cation								1 🗌 Yes	
	28a-f	ect	Maryland Harford  10e. Street and Number		Abe	erdeen	104.7	o Code				100	Citizen ol Wh	at Cour		- ZX
	a or	គ												at Court	iuy:	
	eath	Funeral Director	1420 Willshire D	12. Was Decede	nt Ever in II	S 13 V	_	1001	spanic Origin	n? (Spec	ify Yes or		SA 14. Race -	Americ	an Indian	
10	ter d	F	1 Never Married 2 Married	Armed Force	s?		f Yes, spe	cify Cuba	n, Mexican, F	Puerto R	ican, etc.)			White,		
980	urs ai	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Date			1 🗆 Yes	2√ No	Specify:				Specify:	R1	.ack	
Ŏ	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Itame 23e or 28e-f show ent, the Mardical Example trunklibe rutified at	Completed	15. Decedent's Edu			16a. Deced	dent's Usu	al Occupa	ition			161	o. Kind of Busi			
215	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. L	DO NOT L	ise retired	<i>luring most</i> o )	or working	g					
7	or th	Con	9			Custo	dian					Н	ealth (	are	1	
nd	al Hy	Be (	17. Father's Name (First, Middle, Last)						18. Mother's	s Name (	(First, Midd	dle, Mai	den Surname)			
yla	Ment Ment arked	To	1100	Jester					Emma	<u>(u</u>	nk)	Bel	1			
Maryland 21215-0036	2 sh		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Addres	s (Street a	nd Number	or Rural	Route Nur	n <i>ber, C</i>	ity or Town, St	ate, Zip	Code)	
	and lealth m 27 her t		Cleola Johnson /	Daughter	205 5	1420	Wil	lshir	e Driv	Ve,	Abero	leen	, Maryl	and	21001	Ĺ
0	ges 1 If of H If ita		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from Sta	10	Place of Dispo cemetery, cren							. Location Ci			
Baltimore,	t. Pa ntmen ntent: njury		4 Denation 5 Olylet (Specify)		Hil	ltop S				2–10			wson, N	Mary	Land	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itame 23a or 28a-f show appringury or other traumatic event, the Mudical Exercities must be notified at once.		21. Signature of Funeral Sarvice ulcans	100				nd Addres 35 FU	s of Facility ineral	Hom	e, P.	A.				
- 18			23a. Part1. Enter the disease, or compli	cations that saw	and the deat								on, Mar	yla	nd 210	
			shock, or heart lailure. List only or	e cause on each	ine.			de or dynn	g, such as ca	ardiac or	respirator	y arrest,	1		Interval Bet Onset and I	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			Ann	est							_		
	Examiner				as a conseq	quence of):										
1/3		e.	Sequentially list conditions, if any, leading to immediate		as a conseq	(uence of).										
/	of the d	Examiner	cause. Enter Underlying Cause (Disease or injury	61	ALLIA.	E 70	TH	u vic								
Ć	exection and ial-tra	Exa	that initiated events resulting in death) Last		as a conseq											
8760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		S	( PSI											
9	tifica ng ph as th	ledi														
Вох	th ce tendii r use	an/h	23b. was decedent pregnant	3c. If yes, outcor 1 ☐ Live birth			Ectopic p	regnancy					23d. Date		-	
	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnan 9☐Unknowr	at time of d		Other (s					_	Month	1	Day *	Year
P.O	d by t	Phy	9 Unknown	المحادث علاما		and the same of the same of			- i- D I		02a D	al tabas	co use contrib			fanth?
	ires tha signed d be del	by	Part II. Other significant conditions con	unoung to deat	1 Dut not 1 <del>0</del> 5	sulling in the vi	nderlying	cause give	m in Pari i.						ably 4 🗆	
5	w requir been si should	eted									-					
Division of Vital Records,	elaw hest	Completed										as an itopsy informed	24b. We	re auto or to cor ath?	psy lindings mpletion of c	available ause ol
E E	r. Th										1□ Ye		No 1	Yes	2 No	
<del>=</del>	siciar certif recto	Be	25. Was case referred to medical examiner?	lospital:				O. Othe	26. Place o					_		
ō	Phys ral di	. To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of I		ER/Outpatien 28b. Time of		ŲA	4 Nurs				e 6 Other		y)	
on	ding h. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	м	28c. Injury Work	:? ∕es 2∐No				,,			
/isi	i or Attend after death   Director:   d in by the	fica	3 Suicide 6 Could not be	28e. Place of	Injury - At h	ome, larm, str	eet, lactor	y, office		28	Bl. Location	n (Stree	t and Number	or Rura	i Route Num	nber,
ă	al or	Certification;	4  Homicide determined	building,	etc. (Specia	fy)					City or	Town, S	itate)			
	pspit hours unera y fille		29a. Certifier Certifying Phys	ician: To the be	st of my kno	wledge, death	осситес	at the tim	e, date and	place, ar	nd due to t	he ca <i>u</i> s	e(s) and mann	er as st	tated.	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exami	and manner	stated.	and/or in	vestigation	n, in my of	omion, death	occurre	at the tim	ie, date	and place, an	a aue to	ine cause(s	5)
	To To E	2	29b. Signature and title of certifier	. 10			29	c. License				29d.	Date signed (	Month,	Dey, Year)	
	_/		> fr- Norga	٧ ٧				D	00 65	133			1442	7		
	8		30. Name and address of person who co							20-						
	U	1	Narana Rao Pula			treet,	ELkt	on,	MD 219	121						
*	Sta Registr		31. Date filed (Month, Day Year) 7	2007	gener.	ature	DOL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas O. Jefferson 3:10 a /Medical Nov 30, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care-Irvington Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□**y**M 2□ F Months Director 249-38-1633 Jul 15, 1930 So Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at anne. 10c. City, Town or Location 10d. Inside City Limits 10b. Counfy 1 ☐Yes 2 ☐ No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Pennsylvania Avenue #806 21201 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐ Yes 2☐ No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Water Dept. Water Dept. Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Whitaker Lee Jefferson Susan Jefferson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Black 21 Betlou James Place Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 Donation 5 DOther (Specify) 12/05/07 Baltimore, Md. Western Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

23a. Part1. Enter the disease, or complications that outsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth of the complete Ceurs (Fine). Approximate Interval Between Onset and Death Immediate Cause (Final Physician SNGESTIVE ItE Ani MILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed FAILURE RENAL ding physician and ise as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 HTRERTENSION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď CARDIO MYOPATHY 1 Tes 2 No 3 Probably 4 Unknown Completed 117000 CEPHAMS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 2 7 No 1 ☐ Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA → Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No after death.

I Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

91

State Registrar

31. Date filed (Month, Day, Year) DEC 0 7 2007

:TAMMMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



**ORIGINAL** 

20056948

SULTE 3H BALTIMONE

Primary Carrie

DHMH 17 Rev 1/2001

Physician Midelical Examiner  A. Facility Marin (in ord institution, give shreat and number)  Howard Country General Hospital S. Social Security Number (in ord institution, give shreat and number)  Howard Country General Hospital S. Social Security Number (in ord institution, give shreat and number)  Howard Country General Hospital S. Social Security Number (in ord institution, give shreat and number)  Howard Country General Hospital S. Social Security Number (in ord institution, give shreat and number)  Howard Country General Hospital S. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord institution, give shreat and number)  10. Social Security Number (in ord in shreat Number (in	) 4
As. Feeling Name (If not institution, give street and number)   4c. City, Town, or Location of Death   4c. County of Death   4c. C	
Howard County General Hospital  Funeral Director  Funeral Hudder Year   Hudder 1 Huds   Hudder   Hudder 1 Huds   Hudder 1 Huds   Hudder 1 Huds   Hudder 1 Huds   Hudder   Hudder 1 Huds   Hudder   Hudde	M
Social Security Number   217-40-5356   S. Sex   217-40-5356   S. Social Security Number   217-40-5366   S. Socia	
Director    Description   Desc	oreign
Top	
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	_imits
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	□No
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	
Daniel Justice  Date  Date  Date  Date  Date  Date  Date  Date  Donation 5   Other (Specify)  Date	
Daniel Justice    Paniel Justice   Mary Riddle	
20a. Method of Disposition  **MB Burial 2 Cremation 3 Removal from State  ### Burial 2 Cremation 5 Other (Specify)  Physician  **MB Physician	
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwee Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwee Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwee Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	E
Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwee Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	en
Examiner  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
Per pure the control of the control	
Due to (or as a consequence of):	
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Yes 2   No 9   Unknown   9   Unknown   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Yes 2   No 9   Unknown   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   1   Yes 2   No 3   Probably 4   Month Day Year   1   Yes 2   No 3   Probabl	ti
23e. Did tobacco use contribute to the cause of deat of the cause of death of the cause of the cause of death of the cause of the cause of death of the cause of	th?
1   Yes 2   No 3   Probably 4 Wunk	inown
1   Yes 2   No 3   Probably 4 Wounk  1   Yes 2   No 3   Probably 4 Wounk  24a. Was an autopsy performed? performed? 1   Yes 2 No 1   Ye	ailable se of
27. Manner of Death 14 Natural 28b. Time of Injury (Month, Day Year) 14 Natural 28b. Injury at Work? 28c. Injury at Work?	
27. Manner of Death  1. Natural 5 Pending investigation investigation  28a. Date of Injury 28b. Ilme of Injury 3 Work?  1. Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 3. Suicide 6 Could not be determined 3. Suicide 3. Natural 5 Pending investigation 2 Sec. Injury at Work?  28b. Ilme of Injury at Work?  1. Yes 2 No 28b. Location (Street and Number or Rural Route Number)	
27. Manner of Death 1	1,
27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
29c. License number 29d. Date signed (Month, Day, Year)	
	7
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LEVAN KUCK, How ARD Co. NOSP. Columbia, M.D.  State Registrar  DEC 0 7 2007  32 Registrar's Signature	
State Registrar  31. Date filed (Month, Day, Year)  DEC 0 7 2007  324 Registrar's Signature	

			State of Maryland / Depa	artment of Health and Mental rtificate of Death	3
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Juanita Bell Kellogg	Monti	of Death Day Pear Of Death
	Examir		4a. Facility Name (If not institution, give street and number)  Genesis Loch Raven	4b. City, Town, or Location of Death Parkville	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M x F 7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date e Months Days Hours Min. March	of Birth h, Day, Year) 7, 1926 9. Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore  Park	ocation Eville	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	n with the 3a or 28e	I Direc	10e. Street and Number 8720 Emge Road	101. Zip Code 21 23 4	10g. Citizen of What Country? United States Of America
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-f show eumatic avent. It e Medical Examiner must be muffied at	Completed by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Ouban, Mexican, Puerto Rican, etc.)  1 Yes 22 No Specify:	or No- 14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	od within 72 ho giene. er than "natur , the Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  College (1-4or 5+) N/A	dent's Usual Occupation kind of work done during most of working DO NDT use retired) Housewife	16b. Kind of Business/Industry  At Home
yland	a = 0 %	To Be (	17. Father's Name (First, Middle, Last) Edward A. Godsey	18. Mother's Name (First, M. Thelma	iddle, Maiden Sumame) Andrews
	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailir  Karen J. Flint-Daughter  2773	ng Address (Street and Number or Aural Route N Regal Lane, Oviedo	lumber, City or Town, State, Zip Code) D , FL . 32765
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If itam 27 ia marked any injury or other treumatic as		20a. Method of Disposition 20b. Place of Disposementary, creft 4 Donation 5 Other (Specify)  20b. Place of Disposementary, creft  Morel	matory or other place)	20c. Location - City or Town, State 77 Parkville, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee E	2. Name and Address of Facility VANS FUNERAL (HAPPL, & 800 Harford Rd. Parky:	CREMATION SERVICES 111e, Md. 21234
3,0978	Physician physician and interest as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		ory arrest, Approximate Interval Between Onset and Death
O. Box 68	certific Iding p	Physician/Medic		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
rds, P.	tuires that n signed by lid be deta	þ	Part II. Dther significant conditions contributing to death but not resulting in the ur		Did tobacco use contribute to the cause of death?
Vital Records,	iclan: The law requires that the death certificate has been signed by the atter rector, page 2 should be detached for c	e Completed	25. Was case referred to medical	1 U Y	
Division of Vi	ding Phys	ertification; To Be	examiner?    Hospital:   Inpatient   2 ER/Outpatien	28c. Injury at Work?  M 1 Yes 2 No	Residence 6 □Other (Specify) ribe how injury occurred
	or oric	O	4 Homicide determined 288. Place of injury - At nome, farm, stre	City of	on (Street and Number or Rural Route Number, r Town, State)
	To tha Hospitel within 24 hours a To the Funarel t completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death (Check only one)  1 Medical Examiner: On the basis of examination and/or invand manner stated.  29b. Signature and title of certifier	restigation, in my opinion, death occurred at the ti	ime, date and place, and due to the cause(s)
	¥ 8 5 8	-	I have Attending Physician	29c. License number	Lace mbox 32007 Limber 2/204
	12		30. Name and address of person who completed vause of death (Item 23a) (Type, I	rinst. 4202 But	timore 2/204
	Sta Registra	100	31. Date filed (Month, Day, Year) 32. Registrar's Signature  DEC 0 7 2007	parle	

6

awrence J Koti	oco	State of 1- For State Registrar	f Maryland / Depar <i>Cert</i>	rtment of tificate of		l Mental H		g. No. 200	17 3916
Physici ledical Exami		1. Decedent's Name (First, Middle, Last)  Lawrence J	Kotroco				2. Date of Death Month December		3. Time of Death 1329 hrs
4		4a. Facility Name (if not institution, give s 7 Alder Driver		4	b. City, Town, or L			4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 115-66-3282	7. Age (In yrs. la	st birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	h(MM/DD/YYYY) 9. Bir Foreig	nn
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
<u>*</u> .	5	MD Baltim	ore	Midd	dle Riv	er			1 Yes 2 X No
the Maryla ia or 28a-f	Director	10e. Street and Number 802 Wilson Poi	nt Road		10f. Zip Code 212	20	10	og. Citizen of What Cou	ntry?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygie with 72 hours after death with the Maryland with I filem 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Yes, Give Year	If Ye	s Decedent of Hisp es, specify Cuban,	Mexican, Puerto		White, etc.	ican Indian, Black,
ours aft etural" amine	d by	3 Widowed 4 Divorced If on the property of the	r Dates:	16a. Deceden	Yes 2 X No	on (Give kind of		Specify: 16b. Kind of Business/	
5-0036 led within 72 ho Hygiene, other than "na	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		ost of working life. Cructio		ired)	Building	e E
21215-0036 Muld be filed within 7 Memal Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Julia John Ko				Made	line M.	Maiden Surname) Gossman	
MD 2 d 2 shoul tth and M n 27 is m uumatic e	₽	19a. Informant's Name/Relationship (Type Timothy Kotroc	' '					ber, City or Town, State	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State CI	lace of Disposi rematory or oth	tion (Name of cerr	netery,	Date 2/5/07	20c. Location - City on	Town, State
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		4 Donation 5 Other Specify: 21 Signature of Funeral Strvice License	1) 110	22. N	ame and Address	of Facility 3 (	00 Mace	Ave. Bal	Ltimore MD
Physician		23a. Part I. Enter the disease, or complex fabure. List only one cause on each	ations that caused the death.	Do not enter the	onnelly le mode of dying, s	Y Funer such as cardiac o	ral Homor respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a. I	Or while complicate to (or as a consequence of)		ypothermia	and acute	alcohol :	intoxication	Death
	ner		e to (or as a consequence of)	):					
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a consequence of)	):					
6 be execu sician and burial - tra	ledical	X UNPENDED a.	AMENDED #23a,27,28a-f, p	er. ME.	g874, 12/1	3/07 TT			
6876 ertificat ding ph	an/ľv	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn  Live birth  Pregnant at time of dea	2 Fet	al death 3	Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year
C BOX of the death of the attention by the attentached for us	Physicia	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9 Unknown			iven in Deat I	220 Did to	bacco use contribute to	the source of death?
ords, P.O. w requires that the sbeen signed by should be detach	ò		simboling to death but not re-	salang in the a		veri in r ait i.		2 ✓ No 3 Pro	_
of Vital Records, ag Physician: The law require. The tay require this certificate has been simeral director, page 2 should the strong the second the secon	Completed						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
	Som						perfor		es 2 No
Division of Vital pital or Attending Physician: ours after death teral Director: After this certif filted in by the funeral director,	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2	ER/Outpatient		of Death (Check		Residence 6 ✓ Othe	T. Coope
of Viring Physical After this uneral dir	ا ا	1 ✓ Yes 2 No 27. Manner of Death		28b. Time of Ir		y at Work?		now injury occurred	er: Scene
ion tendin eath. for: A	Certification:	Natural 5 Pending Accident Investigation	1	Fnd 1:19	pm 1 Y	es 2 X No	subject	drowned in co	ld water
Division tal or Attendir rs after death. al Director: A	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, stree		uilding, etc.			ural Route Number, City
Hos 24 h Fur tely	ical Cer	29a. Certifier 1 Certifying Physician:	(Specify) shoreling: To the best of my knowledge in the basis of examination an	e, death occur			due to the cause	e(s) and manner as sta	
To the within To the comple	Medical		nd manner stated.		29c. License			29d. Date signed (Mo	
		Pati . Olem.	-Pollal	M	O.C.N	M.E.		December 4, 20	_
PO		30. Name and address of person who com Patricia Aronica-Pollak MD.	npleted cause of death (Item : Assistant Medical E		111 Penn Str	eet, Baltimor	e, MD 21201	1	
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e	and s				-,
		DEC 0-7 200	A STATE OF THE STA	-		-			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMND TIPM/7, perFH 0875, 1/10/08 WS
State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #8, per FH, 0874, 12/27/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joyce Lucille Kerr 5:25 PM December 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7234 Dockside Lane Columbia Howard 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1934 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 XF 73 <del>-88</del>-157-26-5587 **Director** August 5,1919 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7234 Dockside Lane 21045 U.S.A. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. and 2 should be filed within 72 hours after eath and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Computer Programmer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Inlury or other traumatic evone. Matthew Kerr Nellie Darrah ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Murphy (Niece) 7403 Green Street University Park, FL 34201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Metro Crematory 4 Donation 5 Dother (Specify) 12-10-2007 Catonsville, MD 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility Witzke Funeral Homes, Inc. mo1050 TICK 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atheroscieratic cardiovasculai veals /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dept to for se a consequence off Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the attent detached for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ stenosis, intractaniai aneutysu. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Natural To the mosping after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

RAMDAL

31. Date filed (Month, Day, Year)

DEC 0 7

RIESETT

10700 CHARTER

Registrar's Signature

DRIVE

COLUMBIA, MS ZIDYLY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:18 PM Melvin -gnier 2007 December 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) NC 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 14 Race - American Indian Black, White, etc. Specify: 16b. Kind of Business/Industry Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5130 Yellaward Ave. Baltimore MD 21209

ce of Disposition (Name of Date 20c. Location - City or Town, State Vondkun Cemetery 12/8/dou 1 12/11/11 22. Name and Address of Facility Vougan C. Greene Finerchisery/ros 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory armst,

Appropriate Course (First) Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) December 2, 2007 Dr Patrick McGinlaymo 2401 W. Belvedere Ave Baltimore MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

**Physician** /Medical Examiner Examiner

physician and sthe burial-trans

use as attending

ō

signed by the a

certificate has be rector, page 2 s

director

this funeral

After

ours after death.

within 24 hours a To the Funeral L the Hospital

completely

Physician/Medical

Completed by

Be

Certification: To

Medical

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

or Attending Physician:

Department of H important: If ite any Injury or ot once.

Physician

/Medical

Examiner

**Funeral** 

Director

rai", or items 23a or 28a-f show Examiner must be notified at

the

with

Pages 1 and 2 should be filed within 72 hours after death vent of Heelth and Mental Hygiene.

Int. If item 27 is marked other than "natural", or Items 23s

traumatic event, the Medical

Saltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 ☐ No 1X Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No 27. Manner of Death 1 🔀 Natural

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier MI en Sl

2007

DEC 0

29c. License number D0064615

29d. Date signed (Month, Day, Year) December 5, 2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive, Rockville, Maryland 20850 Genevieve Wroblewski, M.D.

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

32 Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For Amend #20b Per FH 38/4 12/07/07 JH Contificate of Department of Health and Mental Hygiene 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year I anya Evette Mitchell-Smith

4a. Facility Name (If not institution, give street and number)

4b. City, To **Physician** 2:30P M December 3,2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Date of Birth (Month, Day, Year) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F 220-92-9803 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 DY€s 2 No Baltimore Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with Montpelier Street alala Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 "natural", or Specify: Black Š 3 Widowed 4 Divorced Completed Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natur. Iny or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coilege (1-4or 5+) Elementary/Secondary (0-12) State of Maryland ustomer Service hep 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mitchel Hardino Noah 2 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21218

20c. Location - City or Town, State Fields Sister 1522 Homestead St Aleza 20b. Place of Disposition (Name of 1 central lands) 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 12/11/07 Baltimore, Maryland 4 Donation 5 Other (Specify) Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 4905 York had Baltimone MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CNS **Physician** Bleed /Medical Due to (or as a consequence of): **Examiner** 1pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 🗌 Yes 2 □ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 has page this certificate 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 4 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D 2438 2007 leen am Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Union Memorial Hospi Arleen 32. Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 0 7 State 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MANN **Physician** 6 91111 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Street tord Jerry. If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Voarl Hours 260-14-2304 1□M 200 F Yrs seora Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23s or 28s-f ahow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director tartord 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2115 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 I No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: White. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Standard 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Gဥ 2000 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place) other t Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 20c. Location - City or Town, State Date 3 □Removal from State 느ㅎ Department SON Forest VACCIA 12/13/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funcial Chapal + Cremation.
Do not enter the mode of dying, such as cardiac of respiratory arrest, 23a. Part 1. Part? Enter the disease, complications hat shock, or heart failure. List only one cause on at caused the death. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to or as a consequence of): Due to (or es e consequence of): esn 23b. Did tobacco use contribute to the cause of death? cate has been signed by the e page 2 should be detached t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Hinknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 - Yes 2 - No 11 Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) ical Certification: To 1 | Yes 2 | De this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner Death Injury atural 5 Pending

Division of Vital Records, P.O. Box 68760,

efter death.
I Director: Aft
ad in by the fu within 24 hours e To the Funeral D

0,

29b. Signature and title of certifier 30. Name end eddress of person who completed cause of death (

2007

investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

2 No

1 🗆 Yes

Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Nuce Bumby ht will

32 Registrar's Signature

filled in by

completely

2 ☐ Accident

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

DEC 0 7

3 ☐ Suicide

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2200 M December 3 2007 Henry Thomas Morris, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bel Air Harford County Upper Chesapeake Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Feb. 02, 1964 Days Hours 1 ☐ M 2 ☐ F 43 Baltimore,MD. 213-90-3616 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ıral", or items 23a or 28a-f show I Examiner must be notified at Harford County Maryland Joppa 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21805 1012 Joppa Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) r than Elementary/Secondary (0-12) and 2 should be filed withi ealth and Mental Hygiene. Supervisor Joppa Amco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nancy Lee Graham Henry Thomas Morris, Sr. is marked 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joppa, Maryland 21805 permit. Pages 1 and 2 Department of Health a Important: If item 27 is 1012 Joppa Road Mrs. Christine M. Morris (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec.06,2007 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility tives Funeral & Cremation Ctr., P.A. 325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part. Extende disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician tailure /Medical Examiner Hepatic Circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 thinknown alional abuse Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes ivision of Vital 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗜 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 3,2007 00063420 asni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Dr. Bel Air, mp 21014 M.D. 500 Upper

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day BE TT JANE MESSINA 2007 5:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner vindal Home TIMOre If Under 24 Hrs Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**2**F Hours Year) Days 216-28-1250 4 Yrs. Director unburg Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shordical Examiner must be notified at 1 ☐ Yes 2 No MD Director Parkville BALTIMORE 10e. Street and Number 10g. Citizen of What Country? HVenue Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be ပ LICIM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stale, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Joseph MeSSing Jr-Sp 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Edgeword MORP 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State smith 22. Name and Address of Facility 21. Signature of Funeral Service Dicenses 800 Harford Ro BaltimoreMDZIZ: ROLL Ka yans 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listyonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER VARIAN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred I or Attending F after death. 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

D6064533

BATTMORE

2434 W. BELVEDERE

mo

PHYSICIAN

JANI

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

BABATUNDE

Year)

31. Date filed (Month, Day,

12-03-2007

			1 - For State Registrar	State of Maryla		artment of F rtificate of			giene Reg. No. 2007	39174	
	Physic /Medi		1. Decedent's Name (First, Middle, Las	W.		N	1etz	2. Date of Dea Month	Day Year	3. Time of Death	
k	Examin Funeral Director	ner	4a. Facility Name (If not institution, give  The School Hopkin  5. Social Security Number  6. S  234-64-3745	s Hospita	s. last birthday)  6 Yrs.		If Under 24 Hrs Hours Min	8. Date of Birth	y, Year) Cou	uplace (State or Foreign intry)	
	ne Maryland 8a-f show otified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland N/		Balt	imore Ci	ty			10d. Inside City Limits 1 X Yes 2 □ No	
	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	Funeral Dire	10e. Street and Number 3604 Ednor Road 11. Marital Status	12. Was Decedent Ever in	U.S. 13.	10f. Zip Code  Z Was Decedent of H If Yes, specify Cubi	21218 lispanic Origin? (\$		10g. Citizen of What Cou USA  14. Race - Amer	ican Indian,	
-0036	hours after tural", or ite	by	1 X Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec	Armed Forces? 1 X Yes 2 □ No Vi If Yes, Give Year or Dates:	etnam	If Yes, specify Cuba 1 ☐ Yes 2 ☒ No dent's Usual Occup	Specify:	rto Hican, etc.)		hite	
Maryland 21215-0036	filed within 72 Hygiene. other than "na ent, the Medic	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)  4 yrs	(Give	kind of work done DO NOT use retired Vision Ch	during most of wo d)	orking	State of Ma Environmenta	aryland	
ryland	2 should be file and Mental Hy is marked oth aumatic event	To Be (	17. Father's Name (First, Middle, Last)  Cecil Courtney  19a. Informant's Name/Relationship (7)	/ Metz	10h Mailir	18. Mother's Name (First, Middle, Maiden Surname)  Vada Katherine Loar  Iailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
ore, Ma	1 and Health em 27 ther tr		David J. Miller  20a. Method of Disposition	(Pers. Rep.)	3604		ad, Balt		Aaryland 212  20c. Location - City or 1	218	
Baltimore,	permit. Pages Department of Important: If it any Injury or o		1 □ Burial 2 ☒ Cremation 3 □ 4 □ Donation 5 □ Other (Specific 21. Signature of Funcial Service)  Martin D. Lav	Gr	een Mou	ınt Crema	tory 12/	/8/2007   D_FUNERAL	BalBaltimor . HOME, INC. , Maryland	e, Maryland	
8760,	death certificate be executed  Be attending physician and dor use as the burial-transit  Gruse as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a conse	quence of):	er the mode of dyir	ng, such as cardia	ac or respiratory an	rest,	Approximate Interval Between Onset and Death MONH	
P.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fef 4 ☐ Pregnant at time of 9 ☐ Unknown	,		23d. Date of deliv Month	very Day Year			
	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death? bably 4 □Unknown	
Division or Vital Records,	iclan: The law certificate has b ector, page 2 sl	Completed	25. Was case referred to medical					1□ Yes	prior to compared? death? 1 \(\) Yes	opsy findings available ompletion of cause of	
>	ysicle s cert direct	To Be	examiner?	Hospital: 1 Minpatient 2		t 3D DOA Oth	or:	ath (Check only or	<i>ne)</i> lence 6 □Other <i>(Spec</i>		
ion or	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		T	iow injury occurred	<u></u>	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Spec	ify)			City or Tow			
	thin 24 ho thin 24 ho the Fun	Medical	29a. Certifier  (Check only one)  1 **Certifying Physical Examone)  1 **Medical Examone  29b. Signature and title of certifier	ysician: To the best of my kn liner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occ	curred at the time, o	cause(s) and manner as date and place, and due	to the cause(s)	
)	. ∧		Sommer Dri			RES	000	~		0612007	
	Sta Registr	te	30. Name and address of person who of a contract Cropes (31. Date filed (Month, Day, Year)	The Johns Hop  32. Registrar's Sign	Kins Ho		WATION C	hife Street	r, Pallimore, Ma	7.861.6 may	
DHI	MH 17 Rev 1/2	001	ULU V ( 2	our Jugger .	ORI	GINAL					

State Registrar AVYERA HALLI

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

RANDALLSTOWN

HARISH

M00002413 Vital Albert Division or Mover

this certificate Attending Physician: e Hospital or Attendi 24 hours after death. e Funeral Director: A To the Hospital or within 24 hours af To the Funeral D

Completed Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number

00063420

29d. Date signed (Month, Day, Year) December 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Upper Chesapeake Drive Bel Air, MD 21014 Zub Air Kharal

31. Date filed (Month, Day, Year)

7 DEC 0 2007 32. Registrar's Signature

0

Registrar

State

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 2:00 December 4. Gene Maranto 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1611 Chocataw Road Arnold Anne Arundel . Sex 1 M 2 ☐ F if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days Sept. 68 1939 217-34-9177 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 TYes 2FINo Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1611 Chocataw Road 21012 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 🛣 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A <u>Salesman</u> Health & Beauty Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John <u>Maranto</u> Rose <u>Joseph</u> Lascoula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John R. Maranto (Son) 134 Pleasant Springs Drive Centreville Maryland 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/08/07 New Cathedral Cem. Baltimore, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Marvland 21122 21. Signature of Funeral Service Licensee Chin Ahr-to 23a. ... n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PRRYTHMIA Due to (or as a consequence of): ATHEROSCLEROTIC DISEASE ORO WARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of H'TPERLIPIDEMIA Due to (or as a consequence of): TOBACC O DEPENDENCE IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 21110 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner burial-transit and Box 68760 physician the attending I o the detached δ Records, certificate Vital Physician: ō To the Hospital or Attending

funeral

Examiner within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be 2

**Funeral** 

Director

mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan attreet of Health and Mental Hygiene. ortainent of Health and Mental Hygiene. ortain: If item 27 is marked other than "natural", or items 23a or 28a-f show lojury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2::
Department of Health a:
Important: If item 27 Is
any Injury or other trau

Physician

/Medical

Maryland 21215-0036

Baltimore,

Physician/Medical by Completed Be 2 Medical Certification:

W State

Registrar

BRIAN 31. Date filed (Month, Day, Year) **DEC 0 7** 2007

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be

a

116 DEFENSE

0 1

SUITE

400

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100 H

1 ☐ Yes 2 ☐ No

29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DECEMBER 6 2007

21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ND

2. Registrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day YVIAGEE Decomber 4 31.00 AM ZCCT /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arunde If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Director 59 <u>546.80.2849</u> 09.16.1948 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show must be notified 1 ☐Yes 2 📉 No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2304 Crosslanes Way 21113 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ 3 Widowed 4 ☐ Divorced Specify: White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Many Once. Elementary/Secondary (0-12) College (1-4or 5+) Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anne Duvanica <u>Andrew J. Loushin</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 596 Briggs St., Columbus, OH 43206 Sean Magee/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12.07.07 Chesapeake Crem. |Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeal Balto M01443 Alternatives 8717 Green

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Alternatives 8717 Green Pastures Dr. MD Immediate Cause (Final disease or condition resulting in death) auto immune hemolytic anomia - severe **Physician** days /Medical Due to (or as a consequence of): **Examiner** agglutinin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760代 Due to (or as a consequence of): Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acute Kespiratory 1 Tyes 2 No 3 Probably 4 Unknown thromboutopenia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed' Uterine cancer 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 propatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier 1- ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hosp within 24 hor To the Fune

State Registrar

DHMH 17 Rev 1/2001

lacubs mb 31. Date filed (Month, Day, Year) DEC 0

of certifier

29b. Signature an

Hospilel Dr. GlonBurne, mb 2106 305 strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

10022483

29d. Date signed (Month, Day, Year)

# ■ Baltimore. Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

		Please	Type or Print in B						_egible.			
		For State	State of Marylan		artment of F rtificate of							
<b>↑</b> 1	- 7	Registrar  1. Decedent's Name (First, Middle, La	st)		Timoate of	Death	2. Date of Dea	ath	2007	3. Time of D	leath 9	
Physici /Medic		(	Charlotte Ada M	iller			Month December	Day		6:30PM	M	
Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death			County of Deat			
	(a }~		ad Street			Bethesda			Monte	romerv		
Funeral		5. Social Security Number 6. S	M 2KIF	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		9. Birti Co	hplace (State or untry)	Foreign	
Director		108-16-7194 Usual Residence of Decedent	87	110.			October	11,1	920	Michiga	<u>n</u>	
yland now at		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City	Limits	
e Mar la-f sl	ctor	Maryland Monta	omery		В	ethesda				1 □Yes 2	.ĭ∑ No	
or 28	Director	10e. Street and Number	•		10f. Zip Code			10g. Citiz	en of What Co	untry?		
sath w	eral		ad Street			20817				l States		
ter de item	Funeral											
72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sdical Examiner must be notified at	by	3 ♥ Widowed 4 Divorced	If Yes, Give Year or Dates:		1∐ Yes 2X No	Specify:		Specify: White				
72 hor	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	nation	king	16b. Kin	nd of Business/			
ithin 7 Te. Nan "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	Kiriy					
be filed within 72 horal Hygiene. d other than "natuevent, the Medical	S	17. Father's Name (First, Middle, Last	4		Homem		- (Find A811)			Home		
l be fi	Be c					18. Mother's Nam	, ,		,			
should bid Me mark matic	ဥ	19a. Informant's Name/Relationship (	ander Mathes Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru			Krisch	Zin Code)		
nd 2 alth ar 27 is		Marissa A. Mill		İ	' Query M					,	20878	
pes 1 and 2 should be filed within of Health and Mental Hygiens of Health and Mental Hygiens (if item 27 is marked other than or other traumatic event, the Me		20a. Method of Disposition	20b. P	ace of Dispo	sition (Name of		Date		cation - City or		20070	
Pages nent of i		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specit</i>	JRemoval from State (y) C	Mont remato	matory or other place gomery orium Inc	. Dec	ember   2007	Betl	nesda.	Maryland	1	
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licer	psee	Be	2. Name and Addre	ss of Facility Rob	ert A.	Pumpl	nrey Fu	neral Ho nsin Ave	ome/	
0.05.89		- New 1	M003		thesda-C thesda,				MIDEO			
		23a. Part1. Enter he disea e, or m shock, or heart failure. only	one cause on each line.	. Do not ent	17 Sect 1					Approximate Interval Betwee Qnset and De		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Chron	10	LIVER	- tal	lare			LMOR		
Examiner			Due to (or as a consequ	erice or):	FNICO	- Face	hatha	1	1			
	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):		1	/	/				
executed n and ial-transit	Examine	that initiated events	C				/					
oe exe	_	resulting in death) Last	Due to (or as a consequ	ence of):								
icate be executed physician and the burial-transit	dica		_d			-						
leath certifica attending ph	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnal	псу				2	3d. Date of deli	ivon/		
death	iciar	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		∃Ectopic pregnancy ∃ Other (specify)	/		-	Month	Day Ye	ar	
that the de led by the a	hys	9 Unknown	9□Unknown									
	by P	Part II. Other significant conditions of	ontributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.			,	the cause of dea		
requir sen si							1 D Y	′es 20 <b>∑</b>	¶No 3∏Pr	obably 4 ∐Un	known	
e law has b	ompleted						24a. Was autop	sv	prior to c	topsy findings av	ailable ise of	
	0						perfor 1 Yes	rmed? 2 <b>A</b> No	death? 1 ☐ Yes	2□ No		
	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	-5/5 : "	ot all DOA Oth	26. Place of Dea er: —	* 4					
Attending Physician: releath. ector: After this certifica by the funeral director,	2 To	27. Manner of Death	28a. Date of Injury	28b. Time of	IL SELECT	4 LI Nursing H	ome 5 Resid			cify)		
nding th. r: Afte e fune	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ☐ No						
r Atte er dea recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and	Number or Ru	ıral Route Numbe	ə <i>r</i> ,	
ital or irs aft	Ce											
To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar	ysician: To the best of my knowniner: On the basis of examinat and manner stated.	vledge, death ion and/or in	h occurred at the tir vestigation, in my o	me, date and place ppinion, death occu	, and due to the or rred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)		
o the o the o the o the omple	Mec	29b. Signature and tive of certifier	and manner stated.		29c. Licens	e number		 29d. Date	signed (Month	h, Day, Year)		
FSFO		1 4/ans	7 80496	M	)	D0004541	į	Doo	ombon	3 2007		
(C)		30. Name and address of person who		23a) (Type,	Print)	D0004341		Dec	ember :	J, 4007		
75		Gary M. Roggin,	M.D. 10215 Fer	rwood	Road, #40	l Bethes	da, Mary	/land	20817			
Sta Registra	_	31. Date filed (Month, Day, Year)  DEC 0 7 20	32 Registrar's Signat	ure	well?							
negistra	21	UEU U 1 20	01	-								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 3, Mery Cecilia Milla December 2007 5:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 😾 F 40 Director 214-02-1152 December 28,1966 Peru Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5931 Lemay Road 20851 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1√ Yes 2□ No Specify:Peruvian ۵ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Staff Developer Human Resources permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other I any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esteban Milla ပ Emilia Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17607 Silver Dollar Court, Gaithersburg, Maryland 20877 German Milla/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Rockville, Maryland 2007 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 21. Signature of Funeral Service Licensee Pumphrey Funeral Home/ Montgomery Avenue Logn M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Breast Cancer Metastatic to the Brain disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): P.O. Box 68760. attending physician certificate be Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Por in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🙀 No the detached 9□Unknown 9 Unknown þ signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy certificate 1∐ Yes 212 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other Spice 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Division (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064615 December 3, 2007 nore 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Génevieve Wroblewski, M.D./ 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 7 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sarah Ann Manning State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day December 2, 2007 Year **Medical Examiner** 0840 hrs Sarah Α. Manning 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 7202 Mink Hollow Road Highland Howard Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) New York Director Months Davs Hours Min. 215-58-9679 M 2 X F 52 November 23, 1955 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Yes 2 X No Maryland Highland Howard hours after death with the Maryland Director fied at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7202 Mink Hollow Road 20777 United States or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? Never Married White etc. Yes If Yes, Give Year 3 Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 h ment of Health and Mental Hygiene. ant: If item 27 is marked other than "n or other traumatic event, the Medical F-Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Co-Owner 3 Computer Recycling 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John E. Manning Mary Louise Cooney ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4942 Bel Pre Road, Rockville, Maryland 20853 Mary Louise Manning / Mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 December Department (Important: Montgomery Crematorium, Inc. Bethesda, Maryland Other Specify Donation 5 5 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. eletter M01305 Jana 6 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Mixed drug intoxication xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED attending physician or use as the burial .28a-f.perME.g874. 12/24/07 TT Box 68760, IF FEMALE: The law requires that the death certificate 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? Yes 2 🗸 No Yes 2 Nο To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) Be Other: Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Yes 2 X No Director: the FNd 12/2/2007 Fnd 8:30 am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City X Could not be Suicide 7202 Mink Hollow Rd. Highland, MD (Specify) House To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 4, 2007 Tames 30. Name and a the samperson who completed cause of death (Item 23a)

State Registrar

Pamela E: Southall, MD

2007

31. Date filed (Mpt) Cay

Assistant Medical Examiner

32 Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital  Laurel  5. Social Security Number  068 - 12 - 5081  Usual Residence of Decedent  10a. State  10b. County  4b. City, Town, or Location of Death  Laurel  Laurel  Laurel  Funder 1 Year  Months  Days  Hours  Min.  Sept. 11,	No2 1 7 3 1 82 Day 3 2007 2145 M 4c. County of Death Prince George's
Physician /Medical Examiner  Ora A. Mann  December  4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital  Laurel  Funeral Director  Director  Director  Director  Ora A. Mann  A. Mann  4b. City, Town, or Location of Death  Laurel  Laurel  Funder 1 Year  Months  Director  Months  December  Ab. City, Town, or Location of Death  Funder 1 Year  Months  Days  Hours  Min.  Sept. 11,	4c. County of Death Prince George's
Examiner  4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital  5. Social Security Number  Director  5. Social Security Number  068-12-5081  Company  1 M 2 ▼ F  96 Yrs.  4b. City, Town, or Location of Death  Laurel  Laurel  Funder 1 Year   If Under 24 Hrs.   (Month, Day, Yes, Months)   Days   Hours   Min.   Sept. 11, (Month, Day, Yes, Sept. 11, (Month, Da	4c. County of Death Prince George's
Laurel Regional Hospital Laurel    Funeral Director   Director   Usual Residence of Decedent   Laurel   Funeral Director   Laurel   Laurel   Funder 1 Year   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   Sept. 11,	Prince George's
Funeral Director  5. Social Security Number  068-12-5081  6. Sex 1 Months Days Hours Min.  1 M 2 F 96 Yrs.  1 Usual Residence of Decedent	O District Co. 1
Usual Residence of Decedent	
	1911 Virginia
등 <b>보</b> 의   도	10d. Inside City Limits
្ទី ដូទ្ធី 👂 Maryland Howard Columbia	1 □Yes 2 🗖 No
Maryland Howard Columbia  10e. Street and Number  10e. Street and Number  10e. Street and Number	Citizen of What Country?
10565 Route 108  21044  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Merital Status  1 Never Married 2 Married  1 Never Married 3 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Married  1 Never Married 5 Marr	U.S.A.  14. Race - American Indian,
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
Se of the second of the secon	Specify: Black
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Clerk	. Kind of Business/Industry
College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  Clerk	I.R.S.
To see the see that the see tha	den Surname)
Andrew J. Mann  Zenobia Morris  Jacobia Morris	
(Nonhow)	
Alexander J. Whitener 10565 Route 108 Columbia, MD 21  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	Location - City or Town, State
12   Burial 2   Cremation 3   Removal from State   4   Donation 5   Other (Specify)   Columbia Memorial Pk.   12-7-2007   C1	larksville, MD
21. Signature of Funeral Service Locasses Witzke Funeral Homes. Inc.	•
5555 Twin knotts Road Colum	mbia, MD 21045
23a. Part1. Enter the dise of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician  Aspiration Preumonia	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death)  Medical   Machine   M	2 Days
Examiner Septicemia  Sequentially list conditions  Sequentially list conditions	2-3 Weeks
Sequentially list conditions, if any leadin; to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Urinary Tract Infection  Due to (or as a consequence of):	2-3 Weeks
Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Urinary Tract Infection  Due to (or as a consequence of):  Polymic crobial Wound Infection	2-5 WCCR5
Polymicrobial Wound Infection	2-3 Weeks
by sphagia S/P Peg Placement    Solution   State   Sta	
The past 12 months?  If FEMALE: 23c. If yes, outcome pf pregnancy 1 □ I □ Yes 2 ☑ No    I □ Yes 2 ☑ No   I □ Yes 2 ☑ No	23d. Date of delivery  Month Day Year
0	
1   Yes   2   No   9   Unknown   9   Unknown   1   Yes   2   No   9   Unknown   9   Unknown   1   Yes   2   No   9   Unknown   1   Yes   2   No   9   Unknown   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   24e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   23e. Did tobaccon   1   Yes   2   No   9   Unknown   2   No   1   No	to use contribute to the cause of death?
Dysphagia S/P Peg Placement  CAD, Hypertension  Bilateral Hip/Sacral Decubitus Ulcers  23e. Did tobacc  1  Yes  24a. Was an autopsy performed: 1  Yes 2 124.	2 No 3 Probably 4 Unknown
CAD, Hypertension  24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
= F # B   Bilateral Hip/Sacral Decubitus III com	
25. Was case referred to medical examiner?  1   Yes   2   Xes   No	6 Other (Specify)
S E T T T T T T T T T T T T T T T T T T	
M 1 □ Yes 2 □ No  2 □ Accident investigation 3 □ Suicide 6 □ Could not be 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	
A manner of Death 1 Manner of	and Number or Rural Route Number, ate)
ta so so so so so so so so so so so so so	e(s) and manner as stated.
29a. Certifier 29a. C	and place, and due to the cause(s)
₽	Date signed (Month, Day, Year)
	- C 511 - 2000
1 PHYSICIAN DO057216 DI	EC 04 2007
	•

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Physician Medical Examiner    As Feelity Name (If not institution, give street and number)   100. City, Town or Location of Death   100. City   100. City, Town or Location of Death   100. City   100. City, Town or Location of Death   100. City, Town or				1 - For State Registrar	State of M		d / Depa	artmer	nt of H			gien Reg. N	е	J	39183			
Second Directors   Second Dire		/Media	al	Virginia.  4a. Facility Name (If not institution, giv	e street and number)	-KN	AB				Decemb	er D	4, 2	of Death	3. Time of Death 5-4-0 f			
The company of the co				5. Social Security Number 6. S 514–34–1288	ex 7. Ag			If Unde	r 1 Year	If Under 24 Hr.	8. Date of Bir (Month, Da Jan. 10	th ay, Yea, 0,19	916	9. Birthp	ace (State or Foreig			
The part of the pa	th the Maryland	or 28a-f ehow e notified at	Irector	10a. State 10b. County  Maryland Howard		10c. City		lumbi				10g. C	litizen of W		Od. Inside City Limite 1 ☐ Yes 2 No			
Type of the property of the pr	<b>036</b> urs after death wi	al', or itema 23a o Xarvilner must b	by Funeral D	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 21 If Yes, Give	Ev <i>e</i> r in U.	S. 13.		dent of Hi	spanic Origin? ( n, Mexican, Pue	Specify Yes or No to Rican, etc.)		14. Race Blace	- Am <i>e</i> rica k, White, a	etc.			
Sequence of:    Columbia   Columb	1 21215-0( led within 72 hou lygiene.	her then "nature it, the Mudical E				Completed	(Specify only highest gra Elementary/Secondary (0-12)	lucation de completed)	i+)	(Give	kind of wo DO NOT u	ork done d ise retired	luring most of wo		Un Pi	iver: .ttsb:	siness/Ind sity urgh	ustry
Sequence of:    Columbia   Columb	laryland 2 should be fi and Mental H	le marked ot aumatic ever	To Be	Glenn Allen  19a. Informant's Name/Relationship (	*					Sa and Number or R	adie Hall	er, City	or Town,	State, Zip				
Sequence of:    Columbia   Columb	imore, N Pages 1 and nent of Health	ant: If item 27 ury or other tr		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Removal from State		lace of Dispo emetery, crer	sition (Name	me of other place	9)	Date	20c. L	ocation -	City or To	vn, State			
Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Page 19 19 19 19 19 19 19 19 19 19 19 19 19	Balt permit. Departr	Imports any nju		My WCK. H	ademan			2222	TWIL	s of Facility Ineral H I Knolls	omes, In Road C	c. olu			21045			
1	/Me Exa	nysician and he burial-transit	cal Ex	Immediate Cause (Finaf disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as b. Due to (or as c. Due to (or as	CAR a consequ ERT a consequ	uence of):		1800	2CTION				(	Onset and Death			
1   Matural	O. Box 6	attending for use as	hysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant at	2 ☐ Fetaf	death 3					The state of the s			,			
1   Natural     1   Natural     2   Accident     2   Accident     2   Accident     2   Accident     3   Suicide   4   Homicide   4   Homicide   2   Accident     4   Homicide   2   Accident   3   Suicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Accident   4   Homicide   2   Accident   3   Suicide   4   Homicide	ords, r	pe de	ρ	ALZ HE	MER'S	0月1	MENT	TA-	ause give	n in Part I.								
1   Natural     1   Natural     2   Accident     2   Accident     2   Accident     2   Accident     3   Suicide   4   Homicide   4   Homicide   2   Accident     4   Homicide   2   Accident   3   Suicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Accident   4   Homicide   2   Accident   3   Suicide   4   Homicide	Tal HeC	ificate has or, page 2			JOINT	Dil	sea se	Pite-			autop perfo 1 Yes	rmed?	p:	rior to com eath?	pletion of cause of			
29a. Certifier (Chick off) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	SION Of VI anding Physicia sath.	this aldi	ToB	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of	2	28c. Injury Work	Nursing h	lome 5 □ Resid	dence						
D. 3=467 December 5, 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  N. B. VELLANKI, 8850, COLLUMBIA 100 PARKWAY, # 308 COLLUMBIA. MD 21045.	Spital or Att	neral Direct		4 Homicide determined  29a. Certifier 1 Certifying Physics	building, etc	of my know	vledge death	occurred	at the time	e, date and place	City or Tow	vn, Stati	θ)		to d			
1 N.B. VELLANKI, 8850, COLUMBIA 100 PARKWAY, # 308, COLUMBIA. MD 21045.	To the Ho within 24 h	To the Fu completely	<u>e</u> _	one)	men. On the basis of	examinati	ion and/or inv	estigation 29d	, in my op	number	irred at the time,	date an 29d. Da	d place, a	nd due to (Month, D	ay, Year)			
	2	Stat	1	N. R. MELIANKI, 83	50, COLLYM	131A-1	100 PA	RKWAY	1 , *	303 (	<i>olumbia</i>	1.	MD-	2104	5.			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5 2007 August John Naumann Sr. December 5: /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrest Hospice TOWSON Baltimore 8. Date of Birth (Month, Day, Year) 5/8/1916 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) Months Days 91 212-01-5244 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 X No Director MD Baltimore Rosedale 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 7818 Riverdale Ave Completed by Funeral 21237 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 No Fres 2 No Fres Give 1945 – 46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🎾 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metal Finishing Owner Metal Finishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Naumann Mary C. Hotem 2

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7818 Riverdale Ave. Florence Naumann/Wife Rosedale MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Oaklawn Cemetery 12/10/07 Baltimore \_\_MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home atore of Funeral Service Licensee

Chesaco Ave Rosedale MD 21237 Approximate Interval Between Onset and Death

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

19a, Informant's Name/Relationship (Type. Print)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

2 Accident

3 ☐ Suicide

4 Homicide

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

3 ☐ Ectopic pregnancy 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

23d. Date of delivery Month Oay

26. Place of Death (Check only one)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 nknown

45-ARS

Year

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 20 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Datural 5 Pending investigation

6 ☐ Could not be determined

Other: 4 Nursing Home 5 Residence 6 Sther (Specify) HOSPICE 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated. 29c License number

29b. Signature and title

064395

29d. Date signed (Month, Day, Year) DECEMBER 5, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N CHARLES ST, SUITE-209 BALTIMORE MD, 21204 DANIEUE DIBERMEN MO

State Registrar

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. It and Mental Hygiene. It is merked other then "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Exeminer must be notified at</u>

permit. Pages 1 and 2: Department of Heelth a Important: if item 27 is any injury or other trauonce.

**Physician** 

/Medical

Examiner

or Attending Physician: The law requires that the death certificate be executed

After this

i Director: / d in by the f

within 24 hours af To the Funeral D

10+1

Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

31. Date filed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amen #2,perMD,g874, 12/7/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec **Physician** Day EN ONEILL 6.10 PM 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TRANSITIONS-SYKESVILLE Carroll County 9. Birthplace (Stale or Foreign Country) Sykesville 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days Min. 1 □ M 2 ☑ F Director Yrs 153-14-4553 88 1919 New Jersey Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Harford County Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3100 Harford Road death v 21082 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status the Medical Examiner within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or þ 1 ☐ Yes 2 🕅 No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harry Joseph Coughlin Elizabeth Rachel O'Keefe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh William O'Neill (Son) 3100 Harford Road, Baltimore, Maryland 21082 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley Mem Grdns 12/10/2007 Timonium, Maryland 21. Signature 15 m r Service a Karce 1 Martin D. Lawson Mitchell-Wiedefeld Funeral Home, Inc. aus 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscleratic Cardiovascalar Disease Physician /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner certificate be executed and physician a Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy for Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🔼 No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page autopsy certificate 1☐ Yes 2 X No or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month &

DHMH 17 HeV 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D43725

12/06/07

Westminister MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 12:31 am Richard E. O'Neill 2007 December 5, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Calvert Calvert Memorial Hospital Prince Frederick 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 01/29/1933 1**X** M 2 □ F 74 143-24-5094 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 23a or 28a-f show any jour to orber traumatic event, the Medical Examiner must be notified at any julyto or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Lothian MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20711 USA 6075 Fishers Station Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be O'Neill Catherine Dougherty Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6075 Fishers Station Road, Lothian, MD 20711 Horan / Daughter Virginia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3X Removal from State St. Cecilia's Cemetery 12/13/2007 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service License Donote Willandial 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (o) s a consequence of) **Physician** heart Month /Medical Examiner d-Stage re month ren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-transit obstructive hronic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical neumonia the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Asbestusis autopsy perform Adenocarcinoma 1 Yes 2110 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient P 1 ☐ Yes 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled 🛮 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 060390 WO 2007

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL RO.

ORIGINAL

32. Registrar's Signature

Mader

PRINCE FREDERICK, MO

100

DEC 0 7 2007

ADEEB JABER

31. Date filed (Month, Day, Year)

			1 - For Amend #19b Po		2/10/	O7CeHit	icate of	Death	vientai Hy	rgiene Reg. No. 2	007	39187
	Physic /Medi		1. Decedent's Name (First, Middle, L Cynthia Mae		:				2. Date of D Month	Day	Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b	. City, Town, o	or Location of Death			ounty of Death	
	me "	100	SAINT AG		SPIT	AL I	BALTI	MURE			N/A	
1	Funeral Director		214-48-2177	Sex 1 □ M 2 F 7. Age	(In yrs. lasi	t birthday) If Yrs.	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D July 2	rth av. Year) 3, 194	9. Birth Cou Mary	place (State or Foreign ntry) land
W	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Location	on					10d. Inside City Limits
3	Maryl f sho	ō	MD Anne A	Arundel	Li	nthicu	m					1 □Yes 2√2 No
1	r 28a	rec	10e. Street and Number				0f. Zip Code			10g. Citizer	n of What Cou	
2	h with	Funeral Director	1206 Furnace Ro	oad			210	090		Unit	ed Sta	tes
0	ems ems	Iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was	Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N	0- 14.	. Race - Americ	
8-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No if Yes, Give Year or Dates:	)		Yes 2 No					ite
5-6	72 h "natu	etec	15. Decedent's (Specify only highest g	Education trade completed)	1	6a. Decedent (Give kind	s Usual Occup of work done	oation during most of work d)	king	16b. Kind	of Business/In	dustry
121	within ene.	Ig I	Elementary/Secondary (0-12)	College (1-4or 5+	)		VOT use retire ofilm	d)		,		
d 21	Hygie Hygie ther		17. Father's Name (First, Middle, Las	st)		PILCL	OT TIM	18. Mother's Nam	e (First Middle		Allianc	e
な H豆 Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be	William Lowman	,					a Carne		mame)	
70° E	d 2 should Ith and Men 7 Is marke traumatic	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailing A	ddress (Street	and Number or Ru	ral Route Numi	oer, City or T	own, State, Zig	Code)
	4.73 G		Ersie Wilkerson	(Cousin)	:	1206 <del>720</del> 6 Fi	ırnace	Road L	inthicu	m MD	21090	,
Z S	es 1 and of Healt fitem 2 rother		20a. Method of Disposition		20b. Place	e of Dispositio	n (Name of	i	Date		tion - City or To	own, State
fry Baltimore.	permit. Pages 1 an Department of Heal important: If Item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	cify)		owridge	e Memor	ial Park			ridge,	MD
Ba	Depri impo		10. 100	. 7		Gary 7250	/ L. Ka ) Washi	ess of Facility Lufman Fur .ngton Blv	neral He zd. Ell	ome at kridge	MMP, MD 2	Inc. 1075
			23a. Part1. Entey he disease, or conshock, or heart failure. List only	mplications that caused the y one cause on each line	he death. I	Do not enter th	e mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. END	STAG	TE 1						MUNTHS
7	Examiner		1	Due to (or as a		,						
8	- ## (# E	ē.	Sequentially list conditions,	b. HEP	consequent	00.0f):						YEARS
	rifficate be executed ng physician and as the burial-transit	Examiner	Sequentially list conditions, tany, leading transcription cause. Enter Underlying Cause (Disease or injury that initiated events				1-01-	A42.1CE				YEARS
ő	exec an an rial-tr		resulting in death) Last	Due to (or as a	consequen	ce of):	.,	ABUCE				11217123
68760,	ate be nysici he bu	ical		d								
	ertifica ing ph e as th	Med	IF FEMALE:									
₹-i-A		ician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at ti	☐ Fetal de	ath 3 □Ecto	opic pregnancy ner (specify) _	ý		23d	l. Date of delive Month	ery Day Year
1- d	at the by th	hys	9 □ Unknown	9□Unknown								
Zó	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions	_		•	ying cause giv	en in Part I.				ne cause of death?
C Y ecord	requi	ted	DIABETE			105			10	Yes 2□N	No 3 ☐ Prob	ably 4 LUnknown
2, (		Completed by Physician/Medical	HYPER-	TENSION	1				24a. Was auto perfe 1□ Yes	ormed?	24b. Were auto prior to condeath? 1 ☐ Yes	psy findings available mpletion of cause of
O 兄、 Vital R	ilcian: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?					26. Place of Deat	h <i>(Check only</i> i	one)		
Za	<b>shysi</b> this o	2	1 Yes 2 No	Hospital: 1 ☑ Inpatient			□ DOA Oth	er: 4 Nursing Ho	me 5 Res	dence 6	Other (Specif	y)
ZE	ling F	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	/ear) 281	b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe	how injury o	ccurred	
OCO N Division	Attending Physician: r death. ector: After this certifice by the funeral director, i	icat	2 Accident investigation 3 Suicide 6 Could not to		- At home			Yes 2 □ No	20f Looption (	Ctroot and to		10. 1. 11. 1.
⊘ Divis	s after s after al Dire	Certification:	4 ☐ Homicide determined	28e. Place of injury building, etc.	(Specify)	iam, street, i	actory, office	Į.	City or To	wn, State)	umber or Hura	d Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)	thysician: To the best of a miner: On the basis of e and manner state	xamination	dge, death occ and/or investi	urred at the tir gation, in my o	me, date and place, opinion, death occur	and due to the red at the time	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date s	igned (Month,	Day, Year)
			) Oto				P	21617		NOVE	REAT 1	9,2007
	10		30. Name and address of person who		th (Item 23a	a) (Type, Print		** * *		.4 LIV	IDLIK 4	1,400+
	4		ERIC OFUSU,1	ND 900	CAT	on A	UENVI	E, BALTI	MURE	MI	212	29
	Sta Registr	te ar	31. Date filed (Month, Pay, Year) DEC 0 7 2007	32. Registrar's	s gignature	perti						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Grace Hannah /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Baltimore If Under 1 Year | If Under 24 H Months Days Hours M Date of Birth (Month, Day, Year) 10. 22. 1434 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) Social Security Number 6 Sex **Funeral** Months Days 1 □ M 2 189-28-0121 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f show must be notified at 1 TYes 2 DNo MD Director olumbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9264 Lapwing 21045 or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ → o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Ho Specify: Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 □ Divorced þ "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Edgecombe Carry NC filed within Hygiene. College (1-4or 5+) than Elementary/Secondary (0-12) school System eacher is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Pearlie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Dierdre Powell/Daugnter 9264 Lawing Ct. Columbia, MD 21045

e of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 € Burial 2 □ Cremation 3 □ Removal from State 12.4.2007 Baltimore Maryland Gardens of Faith 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Vaughn C. Greene. Furoral Service 21. Signature of Funeral Service Licensee 4905 York Ad Baltimore, Maryland 21212 23a. Part1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PANCREATU CANCER, METASTATIC MONTHS Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the buria eq Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 Do
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by COLONERTAL CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ENDOMETRIAL CANCER 24a. Was an page 2 s autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ 0 Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated the

DHMH 17 Rev 1/2001

State Registrar

DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year)

29b. Signature and title of certific



**ORIGINAL** 

29d. Date signed (Month, Day, Year)

29c. License number

064395

DECEMBER 1, 2007

son who completed cause of death (Item 23a) (Type, Print) USUS N CHARLES ST, SWITE 209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 10:28 PM **Physician** 2007 Evaevie Preisinge Decembe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Medical Cent Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. X⊠M 2□ F Months Days Hours Director 216-28-9271 Jan. 7, 1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☑ No Baltimore County Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 9106 Deviation Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 🎗 🙀 No Specify: Specify: Saltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry Local 486 Plumbers 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) & Steamfitters N/A 10 yrs.Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Clara Voelker John Henry Preisinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 138 Center St. P. O. Box 537 Cecilton, Md. 21913 Jeanette M. Gaskill (Daughter) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12-8-2007 Baltimore, Md. Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INVUOSIS **Physician** /Medical Due to (or as a consequence of): 40 years Examiner abuse 11 CO VIOL Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division or Vital Records, The law requires 3 Probably 4 Walnknown Failine 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has page Jiabetes 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 5 Pending investigation 2 No 1 ☐ Yes 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Samantha

31. Date filed (Month; Day, Year)

225. Greene Street,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2, 12:20 DARLENE YVONNE PICKELL DECEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belcamp 1271 Collier Lane Harford If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Davs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 59 July 8, 1948 214-50-5352 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XNo Director Belcamp Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1271 Collier Lane 21017 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. à Specify: 3 ☐ Widowed 4 ☐ Pivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry George Weiner Jr. Mary Ellen Bell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: if item 27 Is any Injury or other trau 1271 Collier Lane, Belcamp, MD 21017 Laura D. Pickell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 12-7-07 | Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) advanced pancreas cancer **Physician** 12006 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

burial-trar be exec Box 68760, attending physician as the P.O. ed by the a detached f Records. Division or Vital

show

within 72 hours after

and 2 should be filed within ealth and Mental Hygiene. n 27 Is marked other than '

Pages 1

3altimore, Maryland 21215-0036

Certification:

To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the

5 Pending investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifier

6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D53070

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Hpking Hospital 1650 Orkers St Ralt, MD

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

DEC 0 7 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Robinson heodore 30 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner bilitation Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□**/** 2□ F Months Director Maryland Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10b. County If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □ es 2 □ No Director TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ↑ Types 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dermit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; If fem 27 is marked other the any injury or other treasment. ther's Name (First, Middle, Maiden Surname) Be 19a, Informant's Name/Relatio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore. 20c. Location - City or Town, State ethod of Disposition **Z**Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a Insequence of **Physician** disease or condition resulting in death) carcinous /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 - No 1 🗆 Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of çertifier 29c. License number 29d. Date signed (Month, Day, Year) hewe: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar A. Mrowiec
31. Date filed (Month, Day, Year)

DEC 0

2007

0

Blud. Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 Per Phy of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 A 1. Decedent's Name (First, Middle, Last) 2. Date of Deati Nov 27, 2007 **Physician** 7:00 PM JAMES E. RAFFELT OCT /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOSEPH RITCHIE HOSPICE BALTIMORE Under 1 Year If Under 24 Hrs. onths Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 M 2 □ F Director 56 OCT. 31. 1951 DC 156-40-1971 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2247 WESTWOOD DR 20601 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🗷 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEATING MECHANIC MAINTENANCE is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev EDWARD J. RAFFELT MILDRED STRAVACH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2247 WESTWOOD DR., WALDORF, MD TERRY F. RAFFELT/WIFE 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location, - City or Town, State 5500 O DONNELL ST. 1 ☐ Burial 2 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21224 11/30/2007 21. Signature of Funeral Solvice License 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part1. Inter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) encepholopolln **Physician** UNRHOW /Medical Due to (or as a consequence of): Examiner Alcoho Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Cancer Lun 4 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) Yes P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Vital Physician: 25. Was case referred to medical examiner. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2₩No 1 🗆 Y9 2 ER/Outpatient 3 DOA Certification: To Division or 27. Mayner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Bilto Mg 21210-1302 9 W. Like

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Bev 1/2001

0

32: Registrar's Signature

		State of M		artment of Health and	•	•
		1 = For State Registrar		rtificate of Death		10.2007 39193
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	Workinder	Year  25 7 207 4:57 MM  3. Time of Death
Examir Funeral Director	ner	Northwest Washital	ge (In yrs. last birthday) 45 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Mir	8. Date of Birth	Baltrnore 9. Birthplace (State or Foreign Country) 62 NC
Maryland a-f show iffied at	ctor	10a. State 10b. County MD NA	10c. City, Town or Lo			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the	Dire	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?
.UU30 hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	Funeral Director	3952 West Northern Par  11. Marital Status  1 Never Married 2 Married 11. Was Decedent Armed Forces 1 Yes, Give X	Ever in U.S. 13.	21215 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
1 3-0030 172 hours af "natural", or	Completed by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation  kind of work done during most of w DO NOT use retired)		Kind of Business/Industry
within ene.	E E	Elementary/Secondary (0-12) College (1-4or na	5+)	se Assistant		Hospital
IG A e filed il Hygi other ønt, t	Be Co	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	
yland build be file Mental Hy arked oth	10 E	James Smith			e Carter	
<b>DEBITITION</b> Permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)  Talika Brown-Daughter  20a. Method of Disposition	3470 20b. Place of Dispo	ng Address (Street and Number or I  Dolfield Ave position (Name of matory or other place)	, Baltimo	
<b>SAILIMOTE,</b> Jermit, Pages 1 a Department of Hee mportant: If item any Injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Somalure of Funeral Service Licansee (	Metro C	rematory Inc	1/30/07	Baltimore, Md
Deperment any lead		Mun 59 el	e 14	2. Name and Address of Facility larch F/H West 300 Wabash Av	e, Baltimo	ore, Md 21215
Physician /Medical		23a. Par 1. Enter the disease, or complications the cause shick, or her mailure. List only one cause on immediate Cause (mail disease or condition resulting in death)	Seams	ter the mode of dying, such as card	ac or respiratory arrest,	Interval Between Onset and Death
Examiner	L	Due to (or as	s a consequence of):	ane.		davi
γ a is	Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence of):			
ate be executed hysician and he burial-transit	<u>a</u>	that initiated events resulting in death) Last C. Due to (or as	s a consequence of):			
COIdS, P.O. BOX 687 w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medic		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
uires that signed by Id be deta	þ	Part il. Other significant conditions contributing to death	but not resulting in the u	underlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Onknown
The lar	Completed	ESLD 20 N Rep B/C			24a. Was an - autopsy performed 1∐ Yes 2∡	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
VII.a Iclan: Sertific Sector,	Be	25. Was case referred to medical examiner?		Othor:	eath (Check only one)	
OF OF OF OB Physics of the Physics o	ion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, D			Home 5 ☐ Residence 28d. Describe how in	
DIVISION OF i or Attending Phys after death. Director: After this d in by the funeral di	Certification:	3 Suicide 6 Could not be 28e. Place of in	njury - At home, farm, st etc. <i>(Specify)</i>		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
DIVISION DE HOSpital or Attendir n 24 hours after death. he Funeral Director: A	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the besis and manner s	of examination and/or i			
To the within 2 To the complet	Me	29b. Signature and title of certifier	hah	29c. License number		Date signed (Month, Day, Year)  Weshelf 25, 2027
1.		30. Name and address of person who completed cause of	death (Item 23a) (Type			
4	ato	31. Date filed (Month Pay Year) 7 2007 32. Jegis	trar's Signature	Dent Rd	Panas 153	Jun and Just
Si Regis	tate trar	DEC 0 7 2007	eve & A	parks		
DHMH 17 Rev 1/	0001					

1- State of Maryland / Department of Health and Mental Hygiene Registrar Amend #5, perFinf, g874, 12/19/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 5:30 PM Rose Levern )ecomber 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Say 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2 □ F Director 60 19 47 SC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. or 1 terms 23a or 28a-5 show nt: If Item 27 is marked other than "natural", or Items 23a or 28a-5 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 XYes 2 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U.S.A. 21216 5517 Todd Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black þ 2.☐Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Private 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilhelmia Jackson ည Robert Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21206 5517 Todd Ave, Baltimore, Md <del>21216</del> permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra once. Amelia Rose-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/7/07 Baltimore Co, Md Woodlawn 22. Name and Address of Facility
March F/H West
4300\_Wabash\_Ave,\_Baltimore, Md 21. Signature of Eugeral Service Licenses 21215 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal week Acute /Medical Due to (or as a consequence of): **Examiner** clon Cancer with Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 □ Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been sig ge 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Ves 2 No , page 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: itely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 h To the Fu one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0061180 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Radiar's 9 Partway Baltmore, morrland Share 11101 University 31. Date filed (Month, Day, Year) ar's Signature State DEC 0 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

194

Reg. No.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12-05-2007 **Physician** 932 Margaret R. Ruppert /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore 8. Date of Birth (Month, Day, Year) 01-04-1921 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Davs Hours Min 86 Director 220-01-3369 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3206 Canterbury Lane 21047 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Zeller Beatrice McAdams 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Brocato (Daughter) 3206 Canterbury Lane Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department or Important: If any Injury or once. 4 Donation 5 Dother (Specify) 12-10-2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician PSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MEDMONIO Sequentially list conditions, if any, leading to immediate cause Enter United by ground Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-trai Due to (or as a consequence of): pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by aveinoma 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an autopsy performed 2 XN0 or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 ☐ Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 12 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) th 2007 J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

P.O. Box 68760.

07-09392 Victoria Rice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

icto <b>ria</b> Rice	State of Maryland / Department of Health and Mental Hygien	e 2007 0010
	Registrar Certificate of Death	Reg. No. 200/ 39/9
Physician/ ledical Examiner	iner Victoria Kice Mon	ember 4, 2007 0821 nrs
	4a. Facility Name (if not institution, give street and number)  University of Maryland Medical Center  4b. City, Town, or Location of Death  Baltimore	4c. County of Death
Funeral Director	Months   Doug   House   Min	te of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
ow any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show must be notified at once-uneral Director	10e. Street and Number  10f. Zip Code	10g. Citizen of What Country?
death with the laritems 23a or nust be notifie		es or No- 14. Race - American Indian, Black,
fter death ", or iter rer must y Fune	Widowod A Diversed If Ves Give Year	white, etc.  Specify: Black
ours aft		ne 16b. Kind of Business/Industry
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)  College (1-4 or 5+)  18. Mother's Name (First, Middle, Last)	Na
ID 21215-0036 2 should be filed within 72 and Mental Hygiene. 77 is marked other than " untic event, the Medical To Be Comple!	la Nevin Kice   Rach	Middle, Maiden Surname)
MD 21 d 2 should tht and Me n 27 is ma unnatic ev	Place Cost Lv 19b. Mailing Address (Street and Number or Rural Ro	St. Apt 3B Balton, Mp
The second	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date  1 V Burial 2 Cremation 3 Removal from State Arematory or other place)	20c. Location - City or Town, State
.도 ~ 일 등 능	4 Donation 5 Other Specify: MT. Zion Cemerky 12/15	19 Lansdowne, MD
Balti permit. Departi Import injury	Tatelle & Thurses L. Th. 3222 W. North A	uneral Hom, P.A. We Balton, Mb 21216
Physician /Medical	failure. List only one cause on each line.	atory arrest, shock, or heart Approximate Interval Between Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death)  a. Sudden infant death syndrome  Due to (or as a consequence of):	2000:
ner	Sequentially list conditions, b. if any, leading to immediate Due to (or as a consequence of):	
red nsit Examiner	Course. Enter Underlying Course  (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
and and	G.	
760, icate be physicis the buril		23d. Date of delivery
ox 68 ath certif attending or use as	70 1 Yes 2 No 9 Hoknown	Month Day Year
O. Bo at the de- lby the a lached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	e. Did tobacco use contribute to the cause of death?
S, P.O. uires that the risigned by debe detach		Yes 2 No 3 Probably 4 ✔ Unknown
Cords law requi has been 2 should	De 1 24	a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
tal Rection: The certificate ector, page		Yes 2 No 1 Yes 2 No
Vital ysician his certi director	examiner?	
n of Vi ding Physi h. After this funeral dir	27 Manager of Dooth 200 Date of Jainey 200 Time of Jainey 4 Wards 200 Date	escribe how injury occurred
Division of Vital Records, stospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been sizely filled in by the funeral director, page 2 should be all Certification: To Be Completed	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Lo or	cation (Street and Number or Rural Route Number, City Town, State)
Di Hospital 24 hours a Funeral I tely filled		
To the Howithin 24 For the Funcompletely	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	ne, date and place, and due to the cause(s)
Z Z	29b. Signature and title of certifier  29c. License number  O.C.M.E. OCME	29d. Date signed (Month, Day, Year)  December 5, 2007
To Sont	30. Name and address of person who completed cause of thath (Item 23a)	
18	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201
State Registrar	- HI HI HI	

DHMH 17 Rev 1/2001 OCME 2006

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After within 24 hours a

State Registrar DHMH 17 Rev 1/2001

10

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

137

29d. Date signed (Month, Day, Year) December 4 2007

Chase Rad, Edgarater MO 21037

DHMH 17 Rev 1/2001

State

Registrar

Pete Hill, MD,

DEC 0 7 2007

31. Date filed (Month, Day, Year)

600 N.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3Day **Physician** 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ICQ If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Year 1**№** M 2□F Months Days ConneautoH Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced aryland 21215-003 Whit Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUNOS 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OSSear nerman homas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) elane ddle ar c 00 Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State TransFurered Chapal Balthis 4 □ Donation 5 □ Other (Specify) 22. Name and Adress of Facility 21. Signature of Funeral Service Licens vans Funcial Cha complications that caused the only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, of shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** cre Cholecys WREE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): physician Physician/Medical as attending IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cale has been signed by the page 2 shruid be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificale has 1 Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 🖫 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

7

2007

DEC 0

Avenue

NORTH

. Registrar's Signature

BEL AIR

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 39200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** William B. Stanley 14:00 2007 December 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun Rineholt Personal Care Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/22/1927 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 231-24-9414 80 **Director** Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits woys "natural", or items 23a or 28a-f shovedical Examiner must be notified at MD. Rising Sun Cecil 1 ☐Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 1769 Conowingo Road 21911 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Amed Foces: IXYes 2□No IfYes, Give Year or Dates: Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GMElementary/Secondary (0-12) College (1-4or 5+) Factory Worker permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be M. L. Stanley Cora Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 W. 44th Street Apt. 55 NY, NY 10036 Terry Stanley/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel Bel Air Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/5/07 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD. 21. Signs ture of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 3 Newport Drive Brest Hill, MD. 21050 23. P. ntl. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death imer ate Cause r inal di ez e or condition resulting in death) Physician wars /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause pusease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 | Yes 2 | No 3 | Probably 4 | Dronnown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 2 No death? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 133 N Bridge St. nice. 31. Date filed (Month, Day, Year) State DEC 0 7 2007 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		irtment of Health and M tificate of Death	ental Hygien Reg. N	2007	39201
	4575		Decedent's Name (First, Middle, Last)			2. Date of Death	ay Year	3. Time of Death
	Physicia /Medic		Laura M. Snyo	der		December	3 2007	7: 00 A <sup>M</sup>
	Examine		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		lc. County of Death	
	man area and a second and a second		7 Sagebrush Court		Nottingham If Under 1 Year   If Under 24 Hrs.	O. Data of Birth	Baltimo	ore  ace (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) F	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea February 6,	(r) Counti	ry)
	Director		216-01-9885 V	87 Yrs.		recruary of	, 1920 Mary	Tallu
land	at ow	ľ	10a. State 10b. County	10c. City, Town or Lo	cation		10	d. Inside City Limits
Mary	a-f sh fied	ड़ं	Maryland Baltimore	No	ttingham			1 □Yes 2 No
th the	or 28; e not	Director	10e. Street and Number		10f. Zip Code		Citizen of What Count	
th wi	23a (ust b			urt	21236		ted States 0	
er dea	tems ner m	Funeral	Armei	Decedent Ever in U.S. 13. \ d Forces?	Was Decedent of Hispanic Origin? (Spot Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
s after	l", or l		1 ☐ Never Married 2 ☐ Married 1 ☐ Y If Yes 3 ☑ Widowed 4 ☐ Divorced Year	es /2 No , Give or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whit	te
S hou	, and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent's Education	16a. Deced	dent's Usual Occupation kind of work done during most of work		Kind of Business/Ind	ustry
hin 72	an "ng Media	plet	(Specify only highest grade completed [Specify only highest grade completed]  Elementary/Secondary (0-12)  College	life I	DO NOT use retired)		noral Mo	tors
N Mitt	giene er tha , the	Com	12 N	ge (1-4or 5+) A	Statistical T			
<b>2</b>	d oth	Be (	17. Father's Name (First, Middle, Last)	+ a d	18. Mother's Name	e (First, Middle, Maio L. Sal	omon	l
y a	Mentarke arke	유		twood	ng Address (Street and Number or Rur			Code
<b>12</b> sh	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) Deborah Ferrara- D		agebrush Court,	Notting	ham, Mary	land 21236
1 and	Healt em 2 rther		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Location - City or To	
ages	ent of t: If it y or o		1 Burial 2 Cremation 3 Removal f	rom State Parkwoo	d Dec.	7,2007 Pa	arkville,	Maryland
nit. P	ortan ortan injur		21 Signature of Funeral Service Licensee		2. Name and Address of Facility VANS FUNERAL CH			
Der De	Depar Impor any ir once.	<	tativa mi	100	300 Harford . P	arkville	, Maryla	nd 21234
1	<b>%</b> .		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. Do not ent on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Ph	nysician			CONGESTIVE F	TEART FAILUR	E		MUNTHS
	Medical			e to (or as a consequence of):				
<b>-</b>	xaminer	L	Sequentially list conditions, b.	I SCHEMIC e to (or as a consequence of):	CARDIOMYOPATH	7		MONTHS
<b>)</b> 9	is t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence or).			105	
, xecu	al-trar	xar	that initiated events c resulting in death) Last Du	e to (or as a consequence of):				
the death certificate be executed	physician and s the burial-transit	dical						
tificat	ig phy as the	ledi						
ath cer	endin r use	an/N	23b. Was decedent pregnant	s, outcome pf pregnancy Live birth 2 🗆 Fetal death 3[	□Ectopic pregnancy		23d. Date of delive Month	ery Day Year
. e dea	certificate has been signed by the attending Frector, page 2 should be detached for use as	Physician/Me		Pregnant at time of death 5[ Jnknown	Other (specify)			
r tag	d by t letach	Phy	Part II. Other significant conditions contributing	to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Ords, P	signe	b	Type 2 Dia		, ,	1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
	been	etec				24a. Was an	€4b. Were auto	psy findings available
The law requires t	has ge 2 s	Completed				autopsy performed	prior to cou	mpletion of cause of
	ficate or, pa		25. Was case referred to medical		26 Place of Dea	1□ Yes 2 L th (Check only one)	No 1 □ Yes	2   NO
Sicia	s cert	o Be	examiner?	1 ☐ Inpatient 2 ☐ ER/Outpatie	Other		e 6 □Other (Specif	iy)
	er this	I	27. Manner of Death 28a.	Date of Injury 28b. Time of (Month, Day Year) Injury		28d. Describe how i		
	ath. rr: Aft	atio	2 Accident investigation	injury	M 1 ☐ Yes 2 ☐ No			
ທ ±	octo	E S	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.	Place of injury - At home, farm, st building, etc. <i>(Specify)</i>	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura Itate)	al Route Number,
≥ ₹	i e i	12					oo(a) and manner as a	
DIVI	urs after ral Dire	Certification:	CO. Continue district Birth	a the heat of my brandedee de-	th occurred at the time, date and place	and due to the cour		tated.
DIVI	Funeral Directory filled in b		(Check only 2 Medical Examiner: On	the basis of examination and/or i	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the caus rred at the time, date	and place, and due to	tated. o the cause(s)
DIVI	vithin 24 hours after  o the Funeral Dire  ompletely filled in b	Medical Cert	(Check only one) 2 Medical Examiner: On and	the basis of examination and/or i manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to	Day, Year)
DIVIO	within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director, i		(Check only one) 2 Medical Examiner: On and	the basis of examination and/or i	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to	Day, Year)
DIVISION To the Hosnital or Attending	within 24 hours after To the Funeral Dire completely filled in b		(Chack only one) 2 Medical Examiner: On and  29b. Signature and title of certifier  30. Name and address of person who completed	the basis of examination and/or i manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to	Day, Year)
IVIO To the Hospital or At	within 24 hours after To the Funeral Dire completely filled in b		29b. Signature and title of certifier  30. Name and address of person who completed	the basis of examination and/or i manner stated.  I cause of death (Item 23a) (Type	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due to	o the cause(s)
DIVI	9	Medical	29b. Signature and title of certifier  30. Name and address of person who completed from the completed form of the completed from the completed fr	the basis of examination and/or i manner stated.	29c. License number  29c. License number  29c. Alcense number	rred at the time, date	and place, and due to	Day, Year)

DHMH 17 Rev 1/2001

07-09304 Viola Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 39202 Certificate of Death 1- For State Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day December 1, 2007 Physician/ 0355 hrs Examiner Smith Viola 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Maryland General Hospital 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number **Funeral** Hours Months Days 02 13 Country) Director MD 2X F <u> 217-56-65</u>93 М Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1X Yes 2 Baltimore NA MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In prortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number s 23a or 28a-l 21218 U.S.A. 11 West 20th Street Apt 135 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funera or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Black Yes 2 X No Specify Yes 2X No specify: 4 X Divorced If Yes, Give Year Widowed ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Housewife Home 11th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Thomas Oliver Be Otis Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) item 27 is r traumatic Odessa Brockington-Sister 2043 Amber Way, Baltimore, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ltimore, crematory or other place) Cremation 3 Removal from State 1X Burial 2 12/8/07 Baltimore, Md Trinity Donation 5 Other Specify. 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Ligensee 駋 21215 Baltimore. 4300 Wabash Ave, Part I. Enter the disease, or Large Lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ysician Between Onset and failure. List only one cause on each line. Death **Medical** Cocaine intoxication Immediate Cause (Final disease ⊏xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical per\_fb\_e874 12-7-07 X AMENDED XUNPENDED 12/24/07 TT attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Day Year Month 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Part II. Other significant conditions Ö 1 Yes 2 No 3 Probably 4 Unknown þ م. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has performed' 2 No Yes 2 V No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Hospital: Other<sub>4</sub> Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 After this 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 12/1/2007 unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be 11 W. 20th St. Baltimore, MD Suicide determined (Specify) Home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier December 1, 2007 O.C.M.E. whe 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registrar's Signature 31. Date filed (Months Day Year) State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09388 State of Maryland / Department of Health and Mental Hygiene Michael Joseph Smith Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day December 4, 2007 Physician/ 0712 hrs ' Examiner Med: 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Joppa 807 Bartlett Court If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Min. Months Country) Maryland Director 2 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 🗘 No or items 23a or 28a-f show must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 J Married Never Married 2 & No Yes Specify: (1) 1 Yes 2 K No specify: If Yes, Give Year Widowed Divorced "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) nt of Health and Mental Hygiene.

tt: If item 27 is marked other than other traumatic event, the Medical vder MD 21215-0036 IVE 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) egina Be onald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဥ actlett 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, Baltimore, N
permit. Pages 1 and
Department of Healt
Important: If item
injury or other trau 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2007 12 undalk Cemeter Donation 5 Other Specify: 22 Name and Address of Facility
EU ans Funeral Chapel & Cremation Services
88 on Hartord Road Parkuille Md 21232
Approximate 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death dical Narcotic intoxication (methadone, oxycolone, and propoxyphene) Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical XUNPENDED .28a-f, perME,C875, 1/8/08 TT To the Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte I be detached for u 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 V No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available Records, ficate has been si 24a. Was an prior to completion of cause of autopsy performed? death? certificate has 1 🗸 Yes 2 No 1 ✔ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical director, Division of Vital Be Other<sub>4</sub> Hospital: Residence 6 V Other: Scene examiner? Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 1 ✔ Yes this ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: Yes 2 X No Natural Pending unk within 24 hours after death.

To the Funeral Director: Fnd 7:00 am 12/4/2007 filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)
807 Bartlett Ct. 6 X Could not be 3 Suicide determined Joppa, MD single family home (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 completely 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 5, 2007 O.C.M.E. MAD 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD. 3.345 32: Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Roddey James Sanders

oddey James (		I- For State Registrar	e or iviaryland / Dep Ce	ertificate of		siliai i iye		. No. O C	707	20201
Physici	an/	1. Decedent's Name (First, Middle,L					. Date of Death	Day Year		me of Death 916 hrs
ledical Exami	ner	4a. Facility Name (if not institution,	MES SANDERS	- At	o. City, Town, or Location		December -	4, 2007 4c. County of		3101118
m 1		Sinai Hospital	give street and numbery		Baltimore					
Funeral Director		216-50-0014	Sex 7. Age (In yrs.	last birthday) 60 Yrs.		ours Min.		(MM/DD/YYYY)	9. Birthplac Country) MARY	
any	ł	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Locatio	n				10d.	Inside City Limits
<u>*</u>	ь	MD N/	'A	BALT	IMORE CIT	Ϋ́			1 [	XYes 2 No
Maryli r 28a-f	Director	10e. Street and Number 3606 WOODBIN	IE AMENIIE		10f. Zip Code		10	g. Citizen of Wha	at Country?	
vith the s 23a o		11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was	21207 Decedent of Hispanic		cify Yes or No-	USA 14. Race	- American Ir	ndian, Black,
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Marri	ed Armed Forces?	If Ye.	s, specify Cuban, Mexic	can, Puerto R	ican, etc.)	White	, etc.	
rs after ural", o	þ	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:		Yes 2 X No spec s Usual Occupation (Gi		rk done	Specify: 16b. Kind of Bus		ACK
72 hour "nate	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life. DO N			BALTIN	MORE	CITY
0036 within iene. er that	Completed	12	4	E	DUCATOR			PUBLIC		0068
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Be C	17. Father's Name (First, Middle, La RODDEY SANI	1		18.MOI			aiden Surname) TUNSO		
213 nould b id Meni is marl	T0 E	19a. Informant's Name/Relationship		100	Address (Street and I			-		
, ME and 2 sl ealth ar en 27		SHELIA SANDER			WOODBINE			20c. Location -		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medical</u>		1 X Burial 2 Cremation		crematory or othe KING ME	er place) M. PARK	12/	8/07	WINDSO	OR MI	LL, MD
altin mit. P spartme sportas jury or		Donation 5 Other Special     Signature of Funeral Service Lice		22. Na	ame and Address of Fac	cility HC	WELL I	FUNERAI	L HOM	E 21207
		23A Part & Enter the disease, or co	mplications that called the des	46	00 LIBERT	Y HEI	GHTS A	AVE, BA	ALTIM	ORE, MD
Physician /Medical		fa re. List only one cause on Immediate Cause (Final disease	each line. a. Complications of Liver		o mode or dying, odor o		оориштог, т.г.	-,,,	Ве	etween Onset and Death
taminer		or condition resulting in death)	Due to (or as a consequence							
	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):						
	Examine	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence	of):						-
executed an and al - transit		events resulting in deathy Last	d							
760, icate be executed physician and the burial - transit	Medica	UNPENDED	AMENDED					Tani Di i		
876 rtificate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre		al death 3 Ect	topic pregnan	су	23d. Date of Month	delivery Day	Year
Box 687 he death certific the attending p	Physician/	1 Yes 2 No 9 Unkno	Pregnant at time of o	death 5 Oth	er (Specify)			1		
P.O. Es that the digned by the		Part II. Other significant condition		resulting in the ur	nderlying cause given in	n Part I.		pacco use contri		
S, P.O. uires that the n signed by the detached	ed by	Chronic alcoholism								4 Unknown
Records The law requirecte has been a page 2 should	Completed				<u> </u>		24a. Was a autops perfori	sy p		y findings available letion of cause of
tal Reco ciau: The law certificate has ector, page 2 s		25. Was case referred to medical			26.Place of De	eath (Check or	1 Yes 2	2 No 1	✓ Yes	2 No
Vital I ysician: his certifi director,	o Be	examiner?	Hospital: 1 ✓ Inpatient 2	ER/Outpatient	Other			Residence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should I	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) Dec 3, 2007	28b. Time of In		_ ⊩		ow injury occurre following di		orocedure
ision Attend rector: by the	icati	2 Accident Investig	ation 28e Place of Injury - At		1 Yes 2		28f. Location (S	treet and Number	er or Rural R	toute Number, City
Div oital or urs afte eral Dir	Certification:	3 Suicide 6 Could r 4 Homicide determine	ot be				or Town, St			
Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Physical Cone) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurr and/or investigation	ed at the time, date and on, in my opinion, death	d place, and d h occurred at	lue to the cause the time, date a	e(s) and manner and place, and d	as stated. ue to the cau	use(s)
T a F a	Me	29b. Signature and title of certifier	11 01 : 0		29c. License num O.C.M.E.	nber		29d. Date signe December		Jay, Year)
		30. Name and address of person w	no completed cause of death (Its	am 23a)	U.U.IVI.E.			December		
9		Carol Allan, MD Assis	stant Medical Examiner	111 Penn S	treet, Baltimore, I	MD 21201				
S Regis	tate trar	31. Date filed (Month Day, Xear)	2007 32 Registrar's Signa	to Apar	W					
			- 10							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Irma S. Stinson 12-2-2007 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** 5720 Williams Road Harford Hydes 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-26-1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2₩F 77 Yrs. 217-26-2398 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4727 Luerssen Avenue 21206 U.S.A Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Express 12 Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irma Holidge ည Charles R. Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Stinson - Husband 4727 Luerssen Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 12-06-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic **Physician** 3 month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No spital or Attending Physician: Ti nours after death. neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence Hospital: 1 ☐ Inpatient 1 TYes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road # 208, BattAirm, NID 21237

M.D.

32 Registrar's Signature

045390

Jacomber 4, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND 17FW/8 perFH 6874 12/14/07 WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 422 Maude I. Smith December 6,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hand Grenera Baltimore Social Security Number 1922 1955 If Under 1 Year If Under 24 Hrs. 6. Sex vrs. last birthday Date of Birth (Month, Day. Birthplace (State or Foreign
Country) **Funeral** Days March 3 1 □ M 2 □ XF 216-16-6558 85 -Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral" or Items 23a or 28a-f show Examiner must be notified at MD Baltimore Middle River 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Higiene.
Important: I fiem 27 is marked other than "natural" or Items 23a or any houry or other traumatic event, the Medical Examiner must be nust 1601 Wilson Point Road 21220 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 222 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🎾 No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Locheed Martin Administer Assistant 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Henricks Emma V. Gearish P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Torres 2485 Sandhill Road Ellicott City MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 12/10/07 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final neumorua Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-tran attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? es 2 No certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007 DO21207 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) axyland General 31. Date filed (Month, Day, Year) State Registrar 0 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** eona Suter November 30 20017 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Harbor Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Jan. 30 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 ☑ F 215-40-6742 65 MD Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4123 Hague Ave. 1st Floor 21225 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after eath and Mental Hygiene. n 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ε. Rauchhaus ပ Dorothy Beach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health intern 27 is Dennis W. Suter (spouse) 4123 Hague Ave. 1st Floor, Balto. MD 21225 injury or other Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. Date 05 permit. Pages Department of I Important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pertension /Medical **Examiner** temorrhagic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2□ No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6vember30 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21225 tre et

State Registrar 31. Date filed (Month, Day,

2. Registrar's Signature

of Fillit in black indelible link. Ensure All Copies Are Legible.	
e of Maryland / Department of Health and Mental Hygien $2007$	39208
Certificate of Death	

			1 - State Registrar			Cert	ificate of	Death			Reg. No.	, ,	0000								
:	Physici /Medic		1. Decedent's Name (First, Midd Christine	Flossie	Smallw	ood				2. Date of De Dec.	-	20 <b>७</b> ७	3. Time of Death 12:55а м								
¥.	Examir		4a. Facility Name (If not institution Doctor's Col	nmunity Ho	spital		4b. City, Town, o Lanh	am		4c. County of Death											
100	Funeral Director		5. Social Security Number 578-40-5883  Usual Residence of Decedent	6. Sex 7. 1 □ M 2 □ <b>X</b> F	Age (In yrs. last birt) 87		If Under 1 Year Months Days			8. Date of Bir 0 4 - 0 9	**19°20	9. Birthp	place (State or Foreign Inia								
	Maryland a-f ehow	tor	10a. State 10b. County	PG	10c. City, Town	or Loca	chever	ly				1	10d. Inside City Limits  Yes 2 \[ \] No								
	th with the 23a or 28	ai Director	10e, Street and Number 6022 Hawtho:	rne St.			10f. Zip Code 2078	5	f		10g. Citizen	of What Cour SA	ntry?								
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury or other treumatic event. I'm Madical Examitian must be notified at ODGs.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Mai 3 ➡ Widowed 4 □ Divorced		s? 🖸 No	lf '	as Decedent of H Yes, specify Cub	an, Mexicar	n, Puerto R	cify Yes or No lican, etc.)	E	Race - Americ Black, White, cify: Black	etc.								
Maryland 21215-0036	d within 72 hu giene. er then "netu . It'e Medical	Completed		nt's Education st grade completed)  College (1-4c	16a.   or 5+)	Decede (Give ki life. D(	nt's Usual Occup ind of work done O NOT use retire COOK	oation during mos d)	st of workin	g	16b. Kind of	f Business/In ate	dustry								
yland	ould be file Mental Hy arked oth	To Be C	17. Father's Name (First, Middle, Charles	Last) Butler				Lou:			, Maiden Sum ite	name)									
, Mar	and 2 sho ealth and m 27 is ma		19a. Informant's Name/Relation: Starleate Ma	ship (Type, Print) arshall Da	ughter	602		and Number	e St.	. Che	verly,	, MD :	20785								
Baltimore,	Pages 1 ment of H lant: if Ite		20a. Method of Disposition 1	Specify)	te MD Na	tio	nal Ce	m. 1.	2-11-		Laurel										
Balt	permit. Depart Import any Inj once.		21. Signature of Funeral Service	- Day	T	10		orth	Ave	., Ba	ltimor	e, MI	D 21201								
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	Aortic	sed the death. Do not a line.  Valve as a consequence of	Ste		ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death								
(4) (6)	res that the death certificate be executed by the attending physician and be detached for use as the burial-transit	dicai Examiner								Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Conges Due to (or c. Perica	stive Hea as a consequence o rdial E as a consequence o	art n: ffu		re					
P.O. Box 6	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown		2 Fetal death at time of death		ctopic pregnanc Other (specify)	у				Date of delive Month	ery Day Year								
	w requires that been signed t should be det	þ	Part II. Other significant conditi	ons contributing to death	n but not resulting in	the und	derlying cause given	ven in Part I	l.		tobacco use c Yes 2 No		he cause of death? cably 4.⊠Unknown								
Il Records,		Completed		_						24a. Was auto perfo 1 Yes		b. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of								
Vital	Physician: r this certification, rall director, i	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1X Inpa	atient 2 ER/Out	patient	3□ DOA Ott	305		(Check only only only only only only only only	one) dence 6 🗆 (	Other (Specif	(fy)								
Division of	ng Ph fter th neral		Z	igation		ime of jury	28c. Inju Wo M 1	ryat rk? ]Yes 2 ☐		8d. Describe	how injury occ	curred									
DIVIS	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 289. Place of	Injury - At home, far etc. <i>(Specify)</i>	m, stree	et, factory, office		2	8f. Location ( City or To	Street and Nu wn, State)	mber or Rura	al Route Number,								
	he Hosp in 24 hou he Funer pletely fil	edicai	29a. Certifier X Cartifyi (Check only 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination and	death o	occurred at the transition of the transition, in my of	me, date an opinion, dea	nd place, an ath occurre	nd due to the d at the time,	cause(s) and date and place	manner as s e, and due to	stated. o the cause(s)								
)		W	29b. Signature and title of certifi	V (. (	llen	5/	29c. Licens	se number	15		/ 2 / 2	ned (Month,	Day, Year)								
	F Sta	te	30. Name and address of person  Hector Colli 31. Date filed (Month, Day, Year,		Colesvil	le	Rd. Su	ite3	10 S	ilver	Spri	ng, Md	20910								
DH	Registr		DEC 0	7 2007	was it	A.	adi														
						-															

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 2007 **Physician** 5:57P <sup>M</sup> DEC. WILLIAM ARTHUR SMITH, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F Yrs. 213-16-4379 July 11,1921 Maryland Director 86 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Director Baltimore County Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 9 Bailiffs Ct. Unit 101 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner. once. X X Yes 2 No If Yes, Give WW 11 Year or Dates: 1 ☐ Never Married 2X Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Western Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Smith Anna Rose Jerrentrup 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Bailiffs Ct. Unit 101 Timonium, Md. 21093 Bertha G. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 12-12-07 Owings Mills, Md. 4 Donation 5 Dother (Specify) <sup>22</sup> Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 and a state of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ISCHEMIC CARDIOMY OPATH Immediate Cause (Final YEARS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, issuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9□ Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably HIGH CHOLESTEROL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral

Other: 4 Nursing Home 5 Residence 6 Doher (Specify) HOSPICE Hospital: 2 ER/Outpatient 3 DOA 1 | Yes 2 | 1 | Yes 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 ■ Ratural
2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

1401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANKELLE DOBERMANIMO

6565 NCHARLESST, SUITE 209

29c. License number

D64395

BALTIMORE, MO 21204

29d. Date signed (Month, Day, Year)

DELEMBER 5.2007

State Registrar

Certification:

Medical

29b. Signature and title

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 11:25 AM STUMPF 2007 Norman DECEMBER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A HOSPITAL BALTIMORE HARBOR 8. Date of Birth (Month, Day, Year)
Dec. 10,1929 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 MM 2□ F Maryland 77 Yrs 212-26-6469 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Brooklyn Park 1 ☐ Yes 2 No Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 504 Fairfax Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Self-Employed Owner 018. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman Stumpf Helen Calvert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stumpf (Wife) 504 Fairfax Avenue, Baltimore, Maryland 21225 Stella 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 12-08-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Emperal Service Licens McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pproximate pproximate pproximate pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Cancer with Bore Metastasis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dut to for as a consequence off Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2□ No eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)

/Medical Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be

Funeral

Director

if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

within 72 hours after

ould be fi Mental F

permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is
any injury or other trau

**Physician** 

Saltimore, Maryland 21215-0036

Examiner Physician/Medical þ this certificate has been sral director, page 2 should Completed Be P To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certification:

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

as case referred to medical	000	Place of Death

25. Was case referred to medical	26. Place of D				
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	
2 Accident investigation	n		M	1 ☐ Yes 2 ☐ No	

28d. Describe how injury occurred

3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
29a. Certifier	1, Certifying Phys	ician: To the best of my knowledge, death occurred at the

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b.	Signature	and	title	of	certifier	
		,	0		-()	

29c. License number Doctor KESOO 29d. Date signed (Month, Day, Year)

December 4,2007

312all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAIRAH BASHIR 3001 Hanover Street Baltimore, Maryland SOUTH

State Registrar

Medical

31. Date filed (Month, Day, Year) DEC 0 7 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HERALD C. SMITH DECEMBER 4,200 1310 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 77 Jan 19, 1930 West Virginia 232-32-8155 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show didal Examiner must be notified at Anne Arundel Maryland Baltimore 1 ☐Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Waverly Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TXYes 2 □ No If Yes, Give Year or Dates: Kore Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No þ Specify Specify: Korea 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. 12 0 Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. Isom Smith Coral Z. Flanagan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lena L. Smith (Wife) 401 Waverly Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □Cremation 3 □Removal from State Glen Haven Mem Pk 12/10/07 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Ave., Balto., Md. 21225-1856 21. Signature of Funeral Service Licensee Ecker Kevin E 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cute min /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?

1 Yes 24 No 23d. Date of delivery 3 □Ectopic pregnancy Month Dav Vear 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 🗆 No 1□ Yes Hospital or Attending Physician: '44 hours after death.'
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 4 No 1 Hipatient P 2 ER/Outpatient 3□ D0A 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Hatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Gentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) M.D niel 5201 > Ormava 10 x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 aiel East 771 01 31. Date filed (Month, Day, Year) State DEC 0 Registrar 2007

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30 per DVR g874, 12/7/07 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Virginia Jean Schlette 2007 $A^{M}$ December 5:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Crofton Convalescent & Rehab Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 2, 9. Birthplace (State or Foreign Country) Ohio 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🔀 94 055-10-6234 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Maryland| Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Riverwood Dr. 20744 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Instructor Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy A. Gary Vera Hamilton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gene G. Schlette, 407 Riverwood Dr., Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec.6,2007 Metro Crematory Catonsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc., 21. Signature of uneral Ser icensee 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause. Final disease or condition M01290 1630 Edmondson Ave., Catonsville, MD 21228 Approximate Interval Between Onset and Death disease or condition resulting in death) Jementia Due to (or as a consequence of): Athenosclenosis Dusto (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

**Funeral** 

Director

show r 28a-f show notified at

'natural", or items 23a or dical Examiner must be

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examiner burial-tra Physician/Medical the attending ph for use as t \$ Be Completed page 2 s Certification: To this

Physician: After Hospital or Attending s after dec. filled in by within 24 hours at To the Funeral C completely filled

Division or Vital Records, P.O. Box 68760,

osteopon	osis		1 ☐ Yes 2 5	No 3 Probably 4 □Unknown
			24a. Was an autopsy performed? 1  Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Deat	h (Check only one)	
examiner? 1 ☐ Yes _2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 1	OOA Other: 4 Nursing Ho	ome 5 Residence 6	□Other (Specify)
27. Manner of Death 1			28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	nysician: To the best of my knowledge, death occurrenter: On the basis of examination and/or investigation			

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, MD Crofton Convalescent & Rehab Crofton, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 1, 2007 Gerald J. Sophar 3:20 P™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 20, 1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 11XM 2□ F 90 101-09-1492 New York Director Usual Residence of Decedent with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ∐Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3518 Fitzhugh Drive 20906 United States Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 XX Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Information Scientist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Sophar Stephanie Marcus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is other tre Kay Sophar/Daughter 8218 Larry Place, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of Commetery, Crematory or other place)

Montgomery
Crematorium, Inc. 6, 2007

Bethesda, Maryland

22. Name and Address of Facility
Robert A. Pumphrey Funeral Home
Chase Inc.

8 Ethesda, MD 20814-3501 20a. Method of Disposition **₽ =** ₽ 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Unknown Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has the rector, page 2 s autopsy performed death? 2∏ No 1□ Yes 2 🔀 No Hospital or Attending Physician: director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this nours after death.

neral Director; After this
filled in by the funeral d 28b. Time of 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral (
completely filled 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66189 December 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meena/G. 9901 Medical Center Drive, Rockville, Maryland 20850 Andrew, M.D. 32. Gegistrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state 20 Naty and 8 betarment of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Turner PM 1:18 Patricia De 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of maryland, medical Conter Balaimore NIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2000 Months 300-46-4028 Director 60 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at VA Fairfax Reston 1x Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20191 2639 Steeplechase Drive USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify. 3 Widowed 4 Divorced 'natural', er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Biologist is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Alvin Turner Betty Stagg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 i Mark Flemming / Husband 2639 Steeplechase Drive, Reston, VA 20191 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20

Dat 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 🙀 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Bernard, OH 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MI 21. Signature of Funeral Service Licensee W. Marshall arota 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dittuse alvestar /Medical Due to (or as a consequence of): Examiner myelogenou Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signatures 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fi 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number NPI 114 jm 422049 MD Dec

State Registrar

DHMH 17 Rev 1/2001

Baltimore, MD

21201

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

South

32. Registrar's Signature

Jia

31. Date filed (Month, Day, Year)

Che

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:25AN /Medical 4c. County of Death Town, or Location of Death acility Name (If not institution, Examiner more Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age **Funeral** 1**∇**M 2□ F Months Days Hours Min Country Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or 28a-f show unt; if item 27 is marked other than "natural", or items 23a or 28a-f show unt; if whe Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f show 1 Yes 2 No hmor Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 18. Mother's Name (First, Middle, Maiden S 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: if item 27 is marked of any injury or other traumatic evonce. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) (Wife) Patterson Park Ave. Balto 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Jown, State 20a. Method of Disposition 1 V Burial 2 □ Cremation 3 Removal from State 5 Other (Specify) 4 □ Donation Hone 21. Signature of Fune al Service Licenses North Are 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cano **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 24a. Was an autopsy this certificate has perfor 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 🎖 ☐ No 2 ER/Outpatient 3 DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending within 24 hours after uses.... To the Funeral Director: Aft 1 🗌 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Dan

3 . Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Norman Donald Tyler 0233 AM 30 /Medical 2007 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death AGNES HOSPITAL BALTIMORE Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1XM 2□F 216-18-0823 Director 84 10-29-1923 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits notified at Director 1 TYes 2 TYNo Maryland Howard Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 1512 Woodside Avenue 21227 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? WW— 1 X Yes 2 ☐ No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. WW-21 ∑ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2X Married 21215-0036 "natural", or Korean 1 ☐ Yes 2 🛛 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Union Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be f Health and Mental I item 27 is marked o other traumatic eve ဥ Thomas W. Tyler <u>Edna A. Colein</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa F. Tyler - wife If item 27 or other t 1512 Woodside Avenue, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State December Department o Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 4. 2007 Baltimore, Maryland 21. Signature Funeral Service Licens 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M00053 MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LNTRACRANIAL 1.9 hours /Medical Due to (or as a consequence of): Examiner 24 hours HYPERTENSINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perfori certificate Division or Vital 1∏ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital: 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide Hospital or To the Hospital within 24 hours at To the Funeral D filled 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year)

からか

State Registrar JR. HEID MA 31. Date filed (Month, Day, Year)

ABDETHADY

Par)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

900

CATON

BAUTIMORE

30 2007.

AVENUE

_			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of i	Health and I Death	Mental Hy	giene (	007	39217	
	Physici	an	Decedent's Name (First, Middle, L.					2. Date of De Month	eath Day	Year	3. Time of Death	
	/Media	cal	Thomas R. Volke: 4a. Facility Name (If not institution, gi		arl.	Ab Cib. Town	or Location of Death	12	-	2007	09:10 AM	_
	Examir	ier						_		nty of Death		
1	Funeral		Atlantic General 5. Social Security Number 6.	Sex 7.	L Age (In yrs. last birthday)	If Under 1 Year		8. Date of Bir	rth	cester 9. Birthi	nplace (State or Foreign untry)	-
	Director		217-22-9988	1 <b>X</b> M 2□ F	79 Yrs.	Months Days	Hours Min.	04/12/			cyland	
_	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits	_
	Manyl f sho	Po		aton							1 □ Yes 2 🙀 No	
	r 28a	Director	MD Worces  10e. Street and Number	srer	Ocean (	10f. Zip Code			10g. Citizen o	of What Cou	untry?	-
	th with	alD	160 Sandy Hill	Drive		2184	12		U.S.Z	Α.		
	r dee	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No		Race - Ameri		-
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2	No	1 ☐ Yes 2X No			Spe	cifv:		
9	172 hours after deeth with the Maryla "naturel", or Hems 23a or 28a-f shoi idical Examiner must be notified at	ed t	15. Decedent's E	ducation	16a. Dece	edent's Usual Occu	pation		16b. Kind of	Whi Business/In		_
215	thin 72.	ple	(Specify only highest gi	ade completed) College (1-4d	(Give	kind of work done DO NOT use retire	during most of worked)	king			,	
21	be filed within tral Hygiene. od other than svent, the Ma	Completed	11		'	Sorter			Pri	nting	Company	
pur	be fill d off	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam			ame)		
Maryland 21215-0036	d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. It is marked other then "naturst; or Items 23s or 28s-f show traumatic event, the Madical Examiner must be nutified at	ည	Philip J. Volkes  19a. Informant's Name/Relationship		19h Maili	na Address (Stree	Mary A	dele So		en State 7	in Cada)	_
S S	5 5 5 5 5 F		Doris "Eileen"								Land_21842	
Baltimore,	L T S		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Locatio			-
Ë	Pages nent of It ant: If Its ury or of		1 X Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		Gardens o		· 1	8/2007	Baltin	ore. 1	Marvland	
Salt	permit. Page Department of Important: If sny injury or once.		21. Signature of Furt wal Service Lice	nsee	2	2. Name and Addre	ess of Facility $\mathbf{F}_ullet$	F. Lass	ahn Fu	neral	Home, P.A.	
	0 □ E € 0(		Liliana Ja	Som			ir Road -			Maryla		_
			23a. Part1. Enter the disease or conshock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	•			rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		gestive H	leart d	failure	•				_
	Examiner			000 10 (01	as a consequence oi):							
	D =	ner	Sequentially list conditions, if any, leaving to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):							-
12.	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.								
11 <i>c</i> 8760,	e be executed /sicien and e buriat-transit		rosanny m dodiny 2231	Due to (or a	as a consequence of):							
യ	The law requires that the death certificate be executed to the been signed by the ettending physicien and bage 2 should be detached for use as the burral-transi	Physician/Medical		_ d								-
°×	eath certifica ettending pl	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		-			23d. I	Date of delive	/ery	
9988 14 07 0.0.8	deatl	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death 5 [	⊒Ectopic pregnanc ☐ Other (specify) _	;y			M <i>o</i> nth	Day Year	
94 14 P.0	that the deed by the	Phy	9 Unknown					Division Division				_
الا : الا : الا ds, F	signe d be d	Ď	Part II. Other significant conditions	contributing to deatr	n but not resulting in the u	inderlying cause gr	ven in Part I.		tobacco use co Yes 2 □ No		the cause of death?	
چه –۲۱۵ تامن Records	w requires I been signe should be	letec						24a. Was	-		7	
Re J	The lav	Completed						auto	psy ormed?	death?	opsy findings available ompletion of cause of	
3 Vital	W	Be C	25. Was case referred to medical				26. Place of Dear			1 🗆 Yes	2 □ No	-
	uing Physician:  After this certification of the second director.	20	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 XInpa	tient 2 ER/Outpatier	nt 3 DOA Ot	har	ome 5□Resi		Other (Specil	fy)	-
	Ing P	ö	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Ir (Month, L	njury 28b. Time o Day Year) Injury	Wo		28d. Describe	how injury occ	urred		
4/12/18		cat	2 Accident investigation 3 Suicide 6 Could not t	9 99 91	Injury - At home, farm, str		Yes 2 □No	28f. Location (	Street and Nu	mhor or Pur	al Route Number,	
D E	effer effer Direction	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	reet, ractory, ornice		City or To	wn, State)	nuer or nura	ar noute Number,	
Volker, L Dog. L			29a. Certifier 1 Certifying P	hysician: To the be	st of my knowledge, deat	h occurred at the ti	ime, date and place,	and due to the	cause(s) and	manner as s	stated.	
30	the Hin 24 the Fu	Medical	one)	and manner	of examination and/or in	vestigation, in my	opinion, death occur	red at the time,	date and place	e, and due to	o the cause(s)	
	To T To T	2	29b. Signature and title of certifier	)		29c. Licen:	se number 5 412 0		29d. Date sign	ned (Month,		
			1/1/11						1-1/	1/	,	
	Va		30. Na and address of person who Zeeshan, Ati-	completed cause of	death (Item 23a) (Type, 733 Health	way dri	ve Beri	li'n M	·D 21	811		
	Sta	te	31. Date filed (Month, Day, Year)  DEC 0 7	32. R	strar's Signature	<u> </u>						
	Registra	ar	UEC 07	2007	eur & s	made						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Dav **Physician** 232 M 2007 /Medical ity Name (If not institution, gi 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday **Funeral** 1 **™** 2 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat" --- any injury or other traumatic everance. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 es 2 No **Funeral Director** timore 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify. δ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 6 ones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State sings Mills. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** STROKE DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Examiner The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HUPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CORONARY ARTERY DISEASE 24a. Was an autopsy RENAL INSUFFICIENCY 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 5 ☐ Residence 6 Hother (Specify) HOSPICE မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier D64395 DECEMBER 1,2007

Registrar
DHMH 17 Rev 1/2001

6565 N. CHARLES STREET, STE 209

BALTIMORE, NO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE OOBERMAN, MO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- Formend #8 Per FH C874 12/11/00 Phy H Registrar Amend 20b, per FH, g874, 12/7/07 TT Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:15 PM KENNFTH WINGATE 200 03 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOPKIN THE SOHNS BALTIMORE HUSPITIAL CIT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yea**19**51 **Funeral** Days 12 M 2□ F 218.58-4873 53 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 21286 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married 2 4NO 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specity: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ustodiar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၀ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship /Type. Print) Wiaga 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Erenatory Balto. 8-2007 Service P.A. 21. Signature of Funeral Service Licenses Funeral Ba Dan 1701 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 390x. **Physician** COLITIS /Medical Due to (or as a consequence of): Examiner WER FAILURE 2 years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ing physician and design as the burial-transf HIV INFECTION Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1□ Yes 2 No death? 1 ☐ Yes 2□ No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ů 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Nertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier medical doctor RES-000 30. Name and a fress of person who completed cause of death (Item 23a) (Type, Print) BALIGH YEHIA, THE JUHNS HOPKINS HOSPITAL GOON WOLFE ST

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

07-09415 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jessie Lyn Williams State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 2220 hrs December 4, 2007 Jessie Lyn Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8556 Main Street Ellicott City Howard 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 212-19-9857 27 12-03-1980 M 2X F Country)Maryland Yrs Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits is 23a or 28a-f show e notified at once. 28a-f show Harford Jarrettsville 1 Yes 2 X No Maryland death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3609 Duxbury Ct U.S.A. 21084 Funeral 11. Marital Status or items? 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White etc. or i Yes 2 X No DEALTIMOTE, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Widowed Divorced If Yes, Give Year Yes 2 X No specify: event, the Medical Examiner Specify: White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 10 Make-up Artist Self-Employeed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Glenn E. Williams Linda A. Corr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Williams (Mother) 3609 Duxbury Ct Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 12-08-2007 | Fallston, Maryland Highview Mem. Gar. Donation 5 Other Specify. 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee MacPhail Rd Bel Air, MD 21014 610 W. 23d. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line een Onset and /Medical Death Cocaine and narcotic intoxication Immediate Cause (Final disease amine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED burial AMENDED, 27, 28a-f, perME, g876, 2/1/08 TT sician Box 68760. e attending physi for use as the bu IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown signed by the a Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed has been s 24a, Was an prior to completion of cause of autopsy , page 2 s performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> this DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 2 No After th funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural

To the Hospital or Attending Physician: To the Funeral Director: 24 hours after death.

24b. Were autopsy findings available Pending Yes 2 X No unk Fnd 12/4/2007 FNd 10:00 pm Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide 6 X Could not be 8556 Main St. Ellicott City, MD determined (Specify) residence Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number OCME O.C.M.E.

29d. Date signed (Month, Day, Year) December 5, 2007

30. Name and address of person who completed Theodore M. King, Jr., MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registra DEC 0 7

2

3

one)

Medical

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:07 AM noria ウフ 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltmore Medi (4 Baltmore MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F Director 578-60-2419 Usual Residence of Decedent 10/03/1944 63 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Director MD Prince George District Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 ÙSA 1841 Tanow Place 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Iten Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Q Specify:Black 3 ☐ Widowed 4 ☐ Divorced Completed Item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ဥ Laura Warren 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Warren/Daughter 1841 Tanow Pl.District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State mem. Park 12-14-2007Landover, MD 22. Name and Address of Facility 4 Donation 5 ☐ Other (Specify) Harmony Mem. 21. Signature of Funeral Service Licensee Ronald Taylor II FH. Konole North Ave. Baltimore, MD 108 W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician espirator disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-transit Sarco idosis The law requires that the death certificate be executed Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760. physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎝 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an funeral director, page 2 autopsy perform 32 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 FR/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident To the Hospital or Attentum; within 24 hours after death.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Tarn M. Coler, MD 301 St. Paul

Baltimore, MD 21202

St.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ronald **Physician** les 12:08 AM 07 2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Rehab. Extended Care Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04.07.1934 Social Security Number Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**€**M 2 □ F 212.32.0990 73 Director NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notifled at Director 1 ☐ Yes 2 No Fairfax City Fairfax VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8725 Cherry Drive 22031 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Korea Specify þ Specify: White 3 ☐ Widowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturany injury or other traumatic event, Ihm Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pool 12 Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Wolf Florence McCall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Scheider/daughter 8725 Cherry Drive, Fairfax, VA 22031 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville Vet. 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Crownsville Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto 101443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final non-small **Physician** Lung Carcinoma 8 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial P.O. Box 68760, certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been side 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate 2X No Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tenser 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XI North Greene 15altimore

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

DEC 0 7

32, Begistrar's Signature

Physician /Medical Examiner burial-tran Division or Vital Records, P.O. Box 68760,

Department of Health ar Important: If Item 27 Is any injury or other trau

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

<u>م</u>

Completed

Be

ပ္

**Funeral** 

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

Examine physician Physician/Medical the as nse for ed by the a detached f signed by þ page 2 should Completed director, Be Certification: To this funeral . After death.

The law requires that the death certificate be executed or Attending Physician: after death filled in by To the Hospital or within 24 hours at To the Funeral D Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Zukarau December 4, 2007

XI

State Registrar 31. Date filed (Month, Day, Year) DEC 0



			for State Registrar	State of Maryland / D	epartment of F Certificate of	Health and Me Death	ental Hygie		39225
			Decedent's Name (First, Middle, Last				. Date of Death		3. Time of Death
	Physicia		Meredit	n W. Wilson		I	Month December	3, 2007	1:40 P M
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death		4c. County of Death	
			Renaissance Gard	ens	Belts		I	Prince Geo	
П	Funeral		5. Social Security Number 6. S	77 M OF F	Months Davs	Hours Min.	. Date of Birth (Month, Day, Ye	ar) Cour	
	Director		400-22-2531 Usual Residence of Decedent	¥ 2 5 85 Y	rs.		June 26,	1922   Kent	ucky
	land ow	}	10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits
	Mary I sh	to	Colorado Dougla	s Cast	:1e Rock				1 ☐ Yes 2X No
	r 288	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th wit	a	7270 Brixham Cir	c1e		0108		nited Stat	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spec an, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
20	e filed within 72 hours after death with the Maryland Il Hygiene. other then "natural", or Items 23a or 28a-1 show other then "natural", or Items 23a or 28a-1 show ont, Ite M.carel Examirer in the invilled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh	nite
2-0036	hour	edt	15. Decedent's Ed	ucation 16a. I	Decedent's Usual Occu	pation	166	. Kind of Business/In	dustry
212	nin 72 nin "ni	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	Give kind of work done life. DO NOT use retire	during most of working d)	7		
7	d with	Com	Elementary/Secondary (0-12)	4+ Ele	ctrical En	gineer	NA	ASA	
g	be filed within 72 hours after death with the Marylan Ital Hygliene. Id other than Inatural; or flems 23a or 28a-1 show event, Ita M. cheel Examiner in this permitted at	Be (	17. Father's Name (First, Middle, Last,			18. Mother's Name (		den Sumame)	
yland	Ment Ment arka	L <sub>o</sub>	Clyde O. Wilson			Edith We			
Mar	d share the manual strength of the manual str		19a. Informant's Name/Relationship (		Mailing Address (Street				
e,	1 and Health am 2 thar t		20a. Method of Disposition	n Masséy/Daughter 727	Disposition (Name of	Da Da	-	. Location - City or To	
5	ages ont of t: If it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	Hemoval from State	, crematory or other pla lle Cemeter	, I		ckville, M	larvland
altimore,	permit. Pages 1 and 2 should be iil Department of Health and Mental H Important: If item 27 is marked oth any liqury or othar traumatic evan once.		21. Signature of Funeral Service Licer			ess of Facility mphrey Funera			
ñ	Depare Impor any ir		I Chysletic Ba	M01305	300 West Mon	mphrey Funera tgomery Avenu	u Home/Roc e. Rockvil	le, Maryland	1 20850–2805
			23a. Part1. Ever the disease, or com shock, or heart failure. List only	plications that caused the death. Do no					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Parkinson's D	isease				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence o					
	Examiner	L	Sequentially list conditions,	b. Cellulitis  Due to (or as a consequence o	ο.				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Methacillin R		tanh Aureus	1		
٦,	ak-tra	xan	that initiated events resulting in death) Last	c. Due to (or as a consequence of		capit marcat			
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical		Hypovolemia					
٥	tificat ng phy as th	led			-				
ROX	th cer tendir r use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnanc	;y		23d. Date of deliver	ery Day Year
	ō o ō	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify) _			11.01.11.	54,
J.	law requires that the de as been signed by the s i.2 should be detached t			contributing to death but not resulting in	the underlying cause g	ven in Part I.	23e. Did tobac	co use contribute to t	the cause of death?
Vital Records,	uires tha signed I d be det	d by		<b>3</b>	, , ,		1 🗆 Yes	2 No 3 Prol	bably 4 XUnknown
Ö	w require been si should b	Completed					24a. Was an	24b. Were auto	opsy findings available
ě	The lar	dmo					autopsy	d? death?	ompletion of cause of
g		0	25. Was case referred to medical			26. Place of Death	1 □ Yes 2 🔀 (Check only one)	10 100	2010
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA O	her: 4 💢 Nursing Hom	e 5 Residenc	e 6 Other (Speci	fy)
n ot			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28b. T (Month, Day Year) In	jury Wo	ork?	3d. Describe how	injury occurred	
DIVISION	Attending or death. actor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	of Location (Ctms	at and Number of Pur	al Pouts Alumbas
$\leq$	or At after d Diract in by	Certification:	4 Homicide determined		m, street, factory, office	28	City or Town, S	et and Number or Run State)	ar moute ivainber,
_	Hospital 24 hours a Funeral C		29a. Certifier 1 X Certifying PI	sysician: To the best of my knowledge,	death occurred at the t	time, date and place, ar	nd due to the caus	e(s) and manner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical		niner: On the basis of examination and manner stated.					
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licen	se number	29d	Date signed (Month,	Day, Year)
}			* Xachelle	M. aleshon M	D O	44156	De	ecember 3,	2007
	V			completed cause of death (Item 23a) (					
			Rachelle Alexion	del	field Road	, Silver Sp	ring, Ma	ryland 209	904
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 7 2	32 Registrar's Signature	A				
			220012	IVI REGIGE TR	Spells				

DHMH 17 Rev 1/2001

ORIGINAL

07-09367	
Walter Whitley	

Valter Whitley		State of N - For State egistrar	laryland / Departme/ Certifica			Mental H		eg. No. 20	07 3922
Physiciar	1/	1. Decedent's Name (First, Middle,Last)					2. Date of Dea Month		3. Time of Death 1239 hrs
Medical Examin		Walter Whitley  4a. Facility Name (if not institution, give street		Las	o. City, Town, or Lo	esation of Doath	Month Decembe	r 3, 2007 4c. County of D	
		Johns Hopkins Hospital	et and number)	"	Baltimore	ocation of Death	•	N/A	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday)	If Under 1 Year	If Under 24Hrs Hours Min	_	rth (MM/DD/YYYY) 9.	Birthplace (State or breign
Director		214-62-7796 XXM	<sup>2</sup> F 53	Yrs.	Months Days	Hours Mill	5/1/2		Country) Md.
á:	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Locatio	n				10d. Inside City Limits
d how a	_	Md. N/A	Balt	imo	re				1 X Yes 2 No
Maryland 28a-f show any d at once.	Director	10e. Street and Number	Bar		10f. Zip Code		1	l0g. Citizen of What (	Country?
th the Maryland 23a or 28a-f sho notified at once.		3427 Ravenwood A	lvenue		21213	3	ļ	USA	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she af Examiner must be notified at once	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?		Decedent of Hisp s, specify Cuban,			o- 14. Race - A White, et	merican Indian, Black, tc.
er dea		3 Widowed 4 Divorced If Yes	Yes 2 X No	1	Yes 2 X No	specify:		Specify:	Black
urs aft	핡	15. Decedent's Education (Specify only hig	hest grade completed) 16a. [	Decedent'	s Usual Occupation	n (Give kind of		16b. Kind of Busine	
5-0036 led within 72 hours after Hygiene. Hygiene. the Medical Examiner	Completed	, , ,	College (1-4 or 5+)	during mo	st of working life. I	DO NOT use ret	irea)		
within giene.	틹	12 17. Father's Name (First, Middle, Last)	Ma	aint	enance			Baltimo Maiden Surname)	re Schools
	- 1	Walter Whitley, S	Sr			Bessie	Whit:		
2121( ould be fill 1 Mental F 5 marked ic event, 1		19a. Informant's Name/Relationship (Type, F	Print ) 19t		Address (Street	and Number or	Rural Route Nu	mber, City or Town, S	
MD d 2 sh dth and n 27 is		Anita Banks						more, Md	
or Hea	Ш	20a. Method of Disposition 1 XXBurial 2 Cremation 3 Re	emoval from State cremate	ory or oth			Date		
time trent trant:		4 Other Specify: 21/Sid Jure of Funeral Service Licen 6	King						r Mill,Md.
Baltimore, MD 212 permit. Pages I and 2 should b Department of Health and Meni Important: If item 27 is mark injury or other traumatic ver-	+	Old Charles	Lon	ES	tep Bro	others	Funer	al Servi timore,	ce,PA. Md. 21217
Physician	+	23a. Part I. Enter the disease, or complication		ot enter th	e mode of dying, s	uch as cardiac	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical			ute pneumonia						Death
, .	1	or condition resulting in death)  Due to	o (or as a consequence of):						
	힐		o (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):			-			
50, te be executed ysician and burial - transit		d							
D, be exe sician surial -	ledical	X UNPENDED A	592,27,perME,g876,	2/28	/08 TT				
876 tificate ng phy	Ž	Sb. was decedent pregnant in the	c. If yes, outcome of pregnancy Live birth	Fet	al death 3	Ectopic pregn	ancy	23d. Date of de Month	Day Year
Box 68760, c death certificate be the attending physic of for use as the burner of for use as th	<u>Ş</u>	past 12 months?  1 Yes 2 No 9 Unknown g	Pregnant at time of death	=	er (Specify)				Į.
b. BC the dear	Physician/N		Unknown ributing to death but not resultin	g in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use contribu	ite to the cause of death?
P.O. es that the signed by be detacl	<u>۾</u>						1 Y	es 2 🗸 No 3	Probably 4 Unknown
of Vital Records, ag Physician: The law requir Wher this certificate has been shoren director, page 2 should	Completed						24a. Was		ere autopsy findings available or to completion of cause of
eco he law ate has	ğ						perf 1 <b>✓</b> Yes		ath? ✓ Yes 2 No
tal Recians The certificate	Sec.	25. Was case referred to medical examiner?				of Death (Check			
F Vit	٥	1 ✓ Yes 2 No	1 Impatient 2 V 2100	utpatient Time of Ir	•	Other Nurs y at Work?		Residence 6	Other:
ion of tending Phreat. Our. After the funeral	<u>ë</u>	1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	Time of it		es 2 No	200. 2000.	s non nyany addanaa	
Division tal or Attendir rs after death. al Director: A	ertification:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm, stree	t, factory, office bu	uilding, etc.			or Rural Route Number, City
Divi	Ser!	4 Homicide determined	(Specify)				or Town,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil		29a. Certifier (Check only one) Certifying Physician: 7 Medical Examiner: On the control of the control one	Fo the best of my knowledge, de the basis of examination and/or i	ath occur nvestigati	ed at the time, da on, in my opinion,	te and place, ar death occurred	d due to the car at the time, dat	use(s) and manner as e and place, and due	s stated. e to the cause(s)
To t with To t	Medical	29b. Signature and title of certifier	manner stated.		29c. License		-		(Month, Day, Year)
		Ata : ( Iron :	- 1000 dan		O.C.N	Л.E.		December 4	, 2007
nin	-	30. Name and address of person who comp		.1	444 David Ct	root Dalities	no MD 040	01	
IMPIN		Patricia Aronica-Pollak MD.  31. Date filed (Month_Day, Year)	Assistant Medical Exan	niner	111 Penn Str	eet, Baltimo	ле, IVID 212 	U I	-
Sta Registr		DEC 0 7 2007	Been B	Las	A D				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 2007 **Physician** DEC A Cornell Woodard, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₩ 2 F Director 219-52-9481 Mar 3, 1950 So. Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 □ **X** es 2 □ No Director N/A Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1159 Sherwood Avenue 21239 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Sun Papers Apprentice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Woodard Wallace Woodard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1159 Sherwood Avenue Baltimore, Maryland 21239 Sally Woodard Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐Removal from State 1 ☐ **E**urial 2 ☐ Cremation 12/06/07 Windsor Mill, Md. 4 Donation 5 Dother (Specify) King Memorial Park 21. Signature of Funeral Sorvice Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 212 23a. Part1. Effer the dix se, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE SYSTOLIC CARDIOMYOPATHY **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached i 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ STARVATION 1 Yes 2 No 3 Probably 4 Unknown Completed ALCOHOLIC CIRRHOSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ENCEPHALOPATHY death? 1 ☐ Yes performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1₁☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 1 🗀 Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 □ Yes 2 □ No To the Hospital or Attenct within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier n<mark>√Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D0066369 myon 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 5601, LOCHRAVEN BLVD, BALTIMORE MD-21239 32. Agiştrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

WOODARD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12:26 AM 200 velyn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saltimore Gilchri 1 awsor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1□M 2☑F -3502 -23 79 12-21-1927 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show Jeyes 2 No be notified Director Mid autimore altimore 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 2 01224 1011 r than "natural", or Items 23s the Medical Examiner must Funeral 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after in and Mental Hygiene.

Is marked other than "natural", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify. Š 3- Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mather nome maker nome 18. Motber's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be atherine hern ပ Jara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ear Health a Duna Dulch permit. Pages 1 an Department of Heali Important: If Item 2 any Injury or other? Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or others 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Baltimore lawn onvetor 4 ☐ Donation 5 ☐ Other (Specify) 1200 Skorda funeral Home 21. Signature of Funerel Scholice Lice 22. Name and Address of Faility Thomas 410899 Md 2133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a /Medical Due to (or as a consequence of): Examiner eb: ears Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conve uence of) Examine be executed burial-transit ementia and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate and eclerati Ovascu 2 No 1 ☐ Yes 2 No Division or Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICO Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation Iņjury Novamber 22,2007 unknown 1 ☐ Yes 2 ☑ No 9 2 Accident the 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 4 ☐ Hornicide 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

e, Print)

pleted cause of death (Item 23a) (Typ

32. Registrar's Signature

6

Trim

M)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05 PM Day Month **Physician** Zaccoria )ecem 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner at Way - more Age (In yrs. Idea birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1□M 2 🗷 F 179-10-7263 Lancaster Co. Director 10/16/1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director altimore arkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 2922 Manns 2123 Ivenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Me. Jewelry Store Elementary/Secondary (0-12) College (1-4or 5+) perator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hlexander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville md 2922 Manns Are N. Zaccariaaltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland memorial

Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruan's Funeral Chapel + Cremation Syrs-Parkuille 8800 Harford Road Parkville Md 21234 <u>থ</u> Naci 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 11-conf years /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ should be myelounous levium 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed atrial Lbr. Malte 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 22 No page 2 certificate 1□ Yes Anemic or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: ₹
completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Wendy Klorse
31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

H Chazus St Svite 4202

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

D 3119,

Town

md

12/5/07

21204

07-08791	
Theirrien	Allon

heirrien Allen	State of Maryland / Department of Health and Mental Hygiene  1- For State Reg. No.  Certificate of Death Reg. No.
Physician/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  1. Decedent's Name (First, Middle, Last)
Medical Examine	
- 10	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Lanham  4c. County of Death  Prince George's
Funeral Director	5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 578-80-6656 1 X M 2 F 46 Yrs. 1 In Under 24Hrs. 1 If Under 24Hrs. 1 If Under 24Hrs. 1 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 2 In Under 24Hrs. 3 In Under 24Hrs. 4 In Und
any &	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	MD PRINCE GEORGES SEAT PLEASANT
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
th the I	
r death with or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 2 No Security Status 12. Was Decedent Ever in U.S. 1 No Security Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
ifter de	
hours aft natural" Sxamine	
36 nin 72   than " than "	Elementary/Secondary (0-12) College (1-4 or 5+)  12TH WAITER PRIVATE
21215-0036 ald be filed within 72 hour Mental Hygiene. marked other than "natu e event, the Medical Exar	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
1218 d be fill ental F arked vent, f	JAMES ALLEN JOYCE FOX
MD 21 d 2 should Ith and Me n 27 is ms rumatic er	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Informant's Name/Relationship (Type, Print )
e, M I and 2 Health item 2	20q, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
MOF Pages ent of int: If	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: RESURRECTION CEMETERY 11/19/2007 CLINTON, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME
Physician	7474 LANDOVER ROAD LANDOVER, MD 20785  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease Death
,	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.
iner	
uted nd ransit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  d.
60, ate be executed hysician and e burial - transit	W UNPENDED  AMENDED  #23a_27_perME_g874_12/11/07 TT  23d_Date of delivery
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transipation: To Be Commissed by Divisional Madrical Especial Control of the con	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (Specify)
D. Bo the deal by the a ached fo	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Is allow requires that the safer death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach but fitter ation: To Re Commissed by Divitication: To Re Commissed by D	1 Yes 2 No 3 Probably 4 V Unknown
Records, The law require, ficate has been sig., page 2 should be	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
eco he law ite has	actorsy death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recysician: The his certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one)
f Vit. Physici or this c	1 Ves 2 No 1 inpatient 2 Very Erroutpatient 3 DOA 4 Notsing home 5 Residence 0 Other.
n of Ading Pl. th. : After the funeral	
Division o Spital or Attending sours after death. neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Div	3 Suicide 6 Could not be determined (Specify) or Town, State)
To the Hospita within 24 hours To the Funeral completely fille	
F * * * * *	
	Paneth Swithall, May
	30. Na le and address of person which completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat	31. Date filed (Nanth, Day, Year) 32. Registrar's Signature
Registra	NUY 20 2001 Steen D. posses

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

dit D. Adams		1- For State Certificate of Legartine Registrar	Death	eg. No. 2007 3923
Physici	an/	Decedent's Name (First, Middle, Last)	2. Date of Deat	th 3. Time of Death
∕ledical Exami ∱	ner		Month November City, Town, or Location of Death	17, 2007 1611 hrs
			Frederick	Frederick
Funeral			If Under 1 Year   If Under 24Hrs.   8. Date of Bir Months   Days   Hours   Min.	th (MM/DD/YYYY) 9. Birthplace (State or Foreign type chip and the
Director		214-60-1026   1XM 2 F   48 Yrs.	Sept.	7,1959 Foreign Washington
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1	10d. Inside City Limits
* .	'n	MD Carroll Mount Airy		1 Yes 2 X No
daryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	0g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.			21771	USA
0036 within 72 hours after death with the Maryland jeine. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 12. Was Decedent Ever in U.S. 13. Was If Yes	Decedent of Hispanic Origin? ( Specify Yes or No , specify Cuban, Mexican, Puerto Rican, etc.)	<ul> <li>14. Race - American Indian, Black, White, etc.</li> </ul>
her de: ", or i		1 2 Midoured 4 Diversed III Yes Give Year 1 1 V	'es 2 X No specify:	specify: White
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	d by		Usual Occupation (Give kind of work done t of working life. DO NOT use retired)	16b. Kind of Business/Industry
36 n 72 h nan "n lical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  2 Ar	nalyst	Dept. of Defense
-000 d withing giene	com	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, i	
	Be	Kermit Adams	Patricia Kid	ld
	ပ	19a. Informant's Name/Relationship (Type, Print )	Address (Street and Number or Rural Route Nur	
Md 2 alth 3 alth 3 aum 2 aum		Pam A. Adams/Wife 1510  20a. Method of Disposition 20b. Place of Disposition	Terra Oaks Court Mour	20c. Location - City or Town, State
IOFE		1 X Burial 2 Cremation 3 Removal from State crematory or other Removal from State Meadowridg	., ., ., ., ., ., ., ., ., ., ., ., ., .	Elkridge, MD
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5 Other Specify.	me and Address of Facility	
E P P E	- 1	1 / James C/7/ Cen 1495	me and Address of Facility Fanco & Sons, P.A. Sev Gov. Ritchie Hwy. Sev	verna Park Funeral Home verna Park, MD 21146
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac or respiratory arr	Between Onset and
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease or condition resulting in death)  Due to (or as a consequence of):	ase	Death
		Sequentially list conditions.		
	Examiner	if any, leading to immediate Due to (or as a consequence of): cauce. Enter Underlying Cause (Disease or injury that initiated		, a
sit id	xan	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
executed an and al - trans				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
687 certific ding p			death 3 Ectopic pregnancy	Month Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Othe	r (Specify)	
			,,	obacco use contribute to the cause of death?
S, P.C luires that an signed I	ed b	Diabetes Mellitus		s 2 No 3 Probably 4 Unknown
cords law requi has been	Completed by		24a. Was autor	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  at Director: After this certificate has been sided in by the funeral director, page 2 should be	Son		1 🗸 Yes	
Vital Rec hysician: The this certificate	o Be		26.Place of Death (Check only one)  3 DOA Other; 4 Nursing Home 5	Residence 6 Other:
n of V ling Phy After th funeral o	-1	27 Manner of Death 28a Date of Injury 28h Time of Injury		how injury occurred
ion ttendii Jeath. tor: A	atio	1 ✓ Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Divisior ipital or Attend ours after death leral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	factory, office building, etc. 28f. Location ( or Town, \$	Street and Number or Rural Route Number, City State)
Lospita 4 hours unera			d at the time, date and place, and due to the caus	se(s) and manner as stated.
Division To the Hospital or Attendentin 24 hours after death To the Funeral Director:	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		
A FFF	ž	29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		( thortalelle)	O.C.M.E.	November 18, 2007
71/ th		30. Name and address of person who complete cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn 8	Street, Baltimore, MD 21201	
	ate	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	A. A.	
Regis				
DHMH 17 Rev 1/2	001	ORIGINAL		

						Hachble IIIk		-		_	
			For	State of Maryla	and / De	partment of I	Health and I	Mental Hy	giene /	7007	20222
			1 - State Registrar		C	ertificate of	Death		Reg. No.	1007	03202
		9	1. Decedent's Name (First, Middle, La	st)				2. Date of D			3. Time of Death
3	Physici		HARRY G AI	IT YNOHTU	Z .			Month	Day	Year 2007	1903 M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death			ounty of Death	
	Examin	*	UNIVETESITY OF MA	RYLAND MEDICA	L LENTE	TR BAY	TIMORE			N/A	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In y	rs. last birthda	y) If Under 1 Year		8. Date of Bi	rth	9. Birthp	lace (State or Foreign
П	Director		214 34 5242	M 2□F 7	2 Yrs.	Months Days	Hours Min.	DECEMB		34 Cour	MD
	P.		Usual Residence of Decedent	Tie	o:						
	ırylar show	_	10a. State 10b. County		City, Town or					1	0d. Inside City Limits 1 XYes 2 □ No
	e Ma Sa-f s	cto	MD KE	N 1	CH	ESTERT	OWN				TATES 2 INO
	within 72 hours after death with the Maryland piene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Director	10e. Street and Number	~		10f. Zip Code	n :		10g. Citize	n of What Cour	itry?
	th w 23a ust b		304 HADA	WAY DRII	16		21620			4.3	. 4
	r dea ems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	<ol><li>Was Decedent of If Yes, specify Cul</li></ol>	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 14	<ul> <li>Race - Americ</li> <li>Black, White,</li> </ul>	
ထွ	afte or It		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 ☐ Yes 2 No		,		pecify: WH	
215-0036	ours ural"; I Exa	d by	3 Widowed 4 Divorced	Year or Dates:							
2	72 h "natu dica	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De	cedent's Usual Occu ive kind of work done e. DO NOT use retire	ipation e during most of wor	king	16b. Kind	of Business/Ind	dustry
2	vithin ne. han e Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			À -		0		
2	e filed within 72 al Hygiene. other than "nat vent, the Media		17. Father's Name (First, Middle, Last		166	EPHONE	18. Mother's Nan	COYEE			1 CATIONS
ance ance	be be eve	Be	17. Father's Name (First, Middle, Last	^	~			, ,	_	,	
Maryland 21	2 should be and Menta is marked aumatic ev	은	MARRY GAYLURD	ANTHUNI	<u> 38.</u>		13E	HLAH	150	ED	
<u> </u>	au is		19a. Informant's Name/Relationship (	A	19b. Ma	alling Address (Stree	t and Number or Hu	irai Houte Numi	ber, City or	own, State, Zip	Code) 21620
_	s 1 and f Health item 27 other tr		DORIS LEE	ANTHONY	30	4 HADA		ZIVE Date		TERTON	
0	e = 5		20a. Method of Disposition  1XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, c	sposition (Name of crematory or other pla	ace)	21/07	200. Loca	tion - City or To	iwn, State
Baltimore,	□ 10 →		4 □ Donation 5 □ Other (Special		CHUR		Cayeter	2.707	CHU.	eut Hi	ice, MD
ă	permit. Depart Import any inj once.		21. Signature of Funeral Service Lice	nsee MDD	225	22. Name and Addr 205 GEG	ess of Facility	al wine	BILL	CENT ATO	الاسم المالية
_	Q D = @ O		-1/V/20 - V 14	1.00			DO HERV		LITE	3/6/21	
		$\vdash$	1 javou . vo	ruce of		MARVIN	Valley	ams TR	FUN	FRAL D	RECTOR
	SOL		23a. Part1. Inter the disease, or comshock, or heart failure. List only	applications that caused the decone cause on each line.	eath. Do not	MARVIN	Valley	ams TR	FUN	eral D	Annroximate
	Physician		Immediate Cause (Final disease or condition	oplications that caused the de one cause on each line.	eath. Do not e	MARVIN	Valley	ams TR	FUN	ERAL D	RECTOR
	/Medical		Immediate Cause (Final			MARVIN	Valley	ams TR	FUN	TRIL D	Annroximate
			Immediate Cause (Final disease or condition resulting in death)	a. SEPS S  Due to (or as a cons	equence of):	MARVIN	Valley	ams TR	FUN	ral D	Annroximate
	/Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	equence of):	enter the mode of dy	Valley	ams TR	FUN	ral D	Annroximate
	/Medical Examiner	aminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a cons b. Due to (or as a cons c	equence of):	enter the mode of dy	Valley	ams TR	FUN	ERAL D	Annroximate
50,	/Medical Examiner	Fxaminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. SEPS S  Due to (or as a cons	equence of):	enter the mode of dy	Valley	ams TR	FUN	TRAL D	Annroximate
8760,	/Medical Examiner ician and pnrial-transit	ical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a cons b. Due to (or as a cons c	equence of):	enter the mode of dy	Valley	ams TR	FUN		Annroximate
89	/Medical Examiner ician and pnrial-transit	ical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d.	equence of): equence of):	enter the mode of dy	Valley	ams TR	FUN	TRAL D	Annroximate
89	/Medical Examiner ician and pnrial-transit	ical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome pf pre	equence of): equence of): equence of): gnancy etal death	enter the mode of dy	V VIII	ams TR	FUN	d. Date of delive	Approximate Interval Between Onset and Death Aproximate Interval Between Onset and Death April 1988
. Box 68	/Medical Examiner ician and pnrial-transit	ical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Indentying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  yes 2 No	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome pf preg	equence of): equence of): equence of): gnancy etal death	enter the mode of dy	V VIII	ams TR	FUN	ral D	Approximate Interval Between Onset and Death 2 day 5
O. Box 68	/Medical Examiner ician and pnrial-transit	ical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome pf pret 1 □ Live birth 2 □ Fr 4 □ Pregnant at time co 9 □ Unknown	equence of): equence of): equence of): gnancy etal death if death	enter the mode of dy  3 CHEMIA  3 Ectopic pregnants 5 Other (specify)	V VIII	c or respiratory	arrest,	d. Date of deliver	Approximate Interval Between Onset and Death 2 day 5
P.O. Box 68	/Medical Examiner ician and pnrial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. 23c. If yes, outcome pf pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	equence of): equence of): equence of): gnancy etal death of death	enter the mode of dy  SCHEMIA  CHEMIA  CHEMIA	cy	c or respiratory	arrest,	d. Date of deliver Month	Approximate Interval Between Onset and Death O
P.O. Box 68	/Medical Examiner ician and pnrial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. 23c. If yes, outcome pf pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	equence of): equence of): equence of): gnancy etal death of death	enter the mode of dy  SCHEMIA  CHEMIA  CHEMIA	cy	c or respiratory	arrest,	d. Date of deliver Month	Approximate Interval Between Onset and Death 2 day 5
P.O. Box 68	Wedical  we require that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. 23c. If yes, outcome pf pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	equence of): equence of): equence of): gnancy etal death of death	enter the mode of dy  SCHEMIA  CHEMIA  CHEMIA	cy	23e. Did	tobacco use	d. Date of deliver Month  e contribute to the No 3 Prob. 24b. Were auto	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Hecords, P.O. Box 68	The law requires that the death certificate be executed at the area signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. 23c. If yes, outcome pf pred 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	equence of): equence of): equence of): gnancy etal death of death	enter the mode of dy  SCHEMIA  CHEMIA  CHEMIA	cy	23e. Did	arrest,  23  tobacco use Yes 2	d. Date of deliver Month  e contribute to the No 3 Prob. 24b. Were auto	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Hecords, P.O. Box 68	The law requires that the death certificate be executed at the area signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the conditions of the cause of	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome pf prediction of the contributing to death but not reconstributing to	equence of): equence of): equence of): gnancy etal death of death	enter the mode of dy  SCHEMIA  CHEMIA  CHEMIA	cy	23e. Did 1  24a. Wa: aut perl 1  Yes	tobacco use Yes 2 s an posy ormed? 250 No	d. Date of deliver Month  e contribute to the No 3 Protection Protection Protection Code at the Protection Pro	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Vital Hecords, P.O. Box 68	The law requires that the death certificate be executed at the area signed by the attending physician and bage 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a constant of the constant of t	equence of): equence of): equence of): gnancy etal death of death	enter the mode of dy  3 CHEMIA  3 Ectopic pregnants Other (specify)  e underlying cause gi	cy  iven in Part I.  26. Place of Deather:	23e. Did 1 □ 24a. Waa uut peri 1 □ Yes	tobacco use Yes 2 s an oppsy ormed? 228 No one)	d. Date of deliver Month  e contribute to the No 3 Protection Protection Protection Code at the Protection Pro	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
or Vital Records, P.O. Box 68	The law requires that the death certificate be executed at the area signed by the attending physician and bage 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	a. Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome pf pret 1 □ Live birth 2 □ F, 4 □ Pregnant at time o 9 □ Unknown contributing to death but not re	equence of): equence of): equence of): equence of): equence of): equence of):    equence of):	all Ectopic pregnants of the control	cy  iven in Part I.  26. Place of Deather: 4 \( \text{Nursing H} \)	23e. Did 1 □ 24a. Waa uut peri 1 □ Yes	tobacco use Yes 2  s an ppsy ormed? 2 No one) sidence 6	d. Date of deliver Month  e contribute to the No 3 protection of the Protection of the North Protectio	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
or Vital Records, P.O. Box 68	ing Physician: The law requires that the death certificate be executed when the control of the c	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d.  23c. If yes, outcome pf pred 1 □ Live birth 2 □ F 1 □ Pregnant at time of 9 □ Unknown contributing to death but not re 1 □ Live birth 2 □ F 2 □ Live birth 2 □ F 3 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown contributing to death but not re 2 □ Live birth 2 □ F 3 □ Live birth 2 □ F 4 □ Live birth 2 □ F 5 □ Live birth 2 □ F 6 □ Live birth 2 □ F 7 □ Live birth 2 □ F 8 □ Live birth 2 □ F	equence of): equence of): equence of): equence of): equence of): equence of):  ER/Outpat 28b. Time	enter the mode of dy  3 CHEM A  3 Ectopic pregnants Oner (specify)  a underlying cause gill the state of the	cy  iven in Part I.  26. Place of Deather: 4 \( \text{Nursing H} \)	23e. Did 1 □ 24a. Waa uut peri 1 □ Yes  ath (Check only)	tobacco use Yes 2  s an ppsy ormed? 2 No one) sidence 6	d. Date of deliver Month  e contribute to the No 3 protection of the Protection of the North Protectio	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
or Vital Records, P.O. Box 68	ing Physician: The law requires that the death certificate be executed when the control of the c	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to	equence of): equence of): equence of): equence of): equence of): equence of):  equence	and a property of the property	ing, such as cardiac  cy  iven in Part I.  26. Place of Deather: 4 \( \text{Nursing H} \)  iny at ork?  \( \text{Yes} \( 2 \) \)  Yes 2 \( \) No	23e. Did 1 □ 24a. Wait perl 1 □ Yes 28t. (Check only) lome 5 □ Res 28d. Describe	tobacco use Yes 2 san ppsy ormed? 23 No one) idence 6 how injury (Street and	d. Date of deliver Month  e contribute to the No 3 Protection of the Protection of the North Protectio	Approximate Interval Between Onset and Death 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Vital Hecords, P.O. Box 68	ing Physician: The law requires that the death certificate be executed when the control of the c	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a constant of the constant of t	equence of): equence of): equence of): equence of): equence of): equence of):  equence	enter the mode of dy  3 ScHEM A  4 ScHEM A  4 ScHEM A  5 ScHEM A  4 ScHEM A  5 ScHEM A	cy  iven in Part I.  26. Place of Deather: 4   Nursing Hury at ork?  Yes 2   No	23e. Did 1 □ 24a. Wa: aute perf 1 □ Yes ath (Check only) lome 5 □ Res 28d. Describe 28f. Location City or To	tobacco use Yes 2  s an oppsy ormed? 22 No one) idence 6 how injury (Street and wn, State)	d. Date of deliver Month  e contribute to the No 3 Protection Protection Protection Contribute to the No 3 Protection Pro	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset of Death Onset onset onset of Death Onset onset onset of Death Onset onset
or Vital Records, P.O. Box 68	ing Physician: The law requires that the death certificate be executed when the control of the c	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to (or as a cons d. Due to (or as a cons d. Pregnant at time of pregna	equence of): equence of): equence of): equence of): equence of): equence of):  equence	enter the mode of dy  3   Ectopic pregnants   5   Other (specify)   e underlying cause gill   e underlying cause gill	cy iven in Part I.  26. Place of Deather: 4   Nursing Hury at ork?   Yes 2   No	23e. Did 1	tobacco use Yes 2 s an posy ormed? 250 No one) bidence 6 how injury (Street and own, State)	d. Date of deliver Month  e contribute to the No 3 Protection Protection of the Contribute to the No 3 Protection of the North	Approximate Interval Between Onset and Death Death Onset and D
or Vital Records, P.O. Box 68	ing Physician: The law requires that the death certificate be executed when the control of the c	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a constant of the constant of t	equence of): equence of): equence of): equence of): equence of): equence of):  equence	enter the mode of dy  3	cy iven in Part I.  26. Place of Deather: 4   Nursing Hury at ork?   Yes 2   No	23e. Did 1	tobacco use Yes 2 s an ppsy ormed? 250 No one) how injury (Street and wn, State) e cause(s) a h, date and p	d. Date of deliver Month  e contribute to the No 3 Problem of Problem of Specific Control of the	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O
or Vital Records, P.O. Box 68	The law requires that the death certificate be executed at the area signed by the attending physician and bage 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cons b. Due to (or as a cons c. Due to (or as a cons d. Due to	equence of): equence of): equence of): equence of): equence of): equence of):  equence	enter the mode of dy  3 ScHEM A  4 ScHEM A  5 ScHEM A  4 ScHEM A  5 ScHEM A	cy iven in Part I.  26. Place of Deather: 4   Nursing Hury at ork?   Yes 2   No	23e. Did 1	tobacco use Yes 2 s an ppsy ormed? 250 No one) how injury (Street and wn, State) e cause(s) a h, date and p	d. Date of deliver Month  e contribute to the No 3 Protection Protection of the Contribute to the No 3 Protection of the North	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEPARTMENT OF EMERGENCY MEDICINE GITH FLOOR SWITEZOD

Alexander Wielaard, MD

110 S. FACA STREET

BALTIMORE, MD Z1201

		1 - For State Registrar	State o	of Maryland		rtment of H			giene Reg. No.	007	392	33
Physic	ion	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	ath Day	Year	3. Time of I	Death
Physic /Med		Donna		Ann		Bratter		11	19	2007	1:10	PM
Exami	iner	4a. Facility Name (If not institution		mber)		4b. City, Town, or		th		ounty of Death		
		31950 Rushmore 5. Social Security Number	Drive 6. Sex	7. Age (In yrs. las	st birthday)	Parsons If Under 1 Year		8. Date of Birt	h	COMICO 9 Birtho	lace (State or	Foreign
Funera Director		219-60-1571	1 ☐ M 2 🂢 F	53		Months Days	Hours Min		y, Year)	Cour	vland	
pu ,		Usual Residence of Decedent		10- 07-	T				<i></i>			.12-2-
ith the Marylar or 28a-f show	ž	10a. State 10b. County		Toc. City,	Town or Lo	cation				1	0d. Inside City 1 ☐ Yes	
the M	Director	MD Wicom	ico	Par	sonsb	1rg 10f. Zip Code			10a Citizo	n of What Cour		22,110
with a or	i Dir	31950 Rushmore	Drivo			2184	0			II or what cour	itiy r	
I E, INICAL Y ICALICAL CANDON  1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Eventinal candidation	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	. 13. \	Vas Decedent of Hi Yes, specify Cuba		Specify Yes or No-	USA 14	. Race - Americ		
or Ite		1 ☐ Never Married 2X Marri	Armed For ed 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	orces? 2 No				rto Rican, etc.)		Black, White,		
ours ours	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		☐ Yes 2X No	Specify:		5)	pecify: Whi	te	
natu	Completed	15. Decedent (Specify only highes			(Give	tent's Usual Occupa kind of work done of OO NOT use retired	during most of wo	orking	16b. Kind	of Business/Inc	dustry	
withir Bne. then	d m	Elementary/Secondary (0-12)	College (	1-4or 5+)			,		Dool	l Estate	_	
II y Idillo Z 1 Z should be filed within nd Mental Hygiene. marked other then imatic event, the M	Ø	17. Father's Name (First, Middle,	Last)		COIIC	cact Mana		me (First, Middle,			3	
ild be fental ked d	To B	Joseph A. Danie	e1				Nancy F	Ruth Mill	er			
Tally Iallu Z 1 Z 2 should be filed with and Mental Hygiene. 1s marked other there summatic event, Ireal	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Street a				own, State, Zip	Code)	
of Health a litem 27 la		Bill Bratten -	Husband		31950	Rushmore	Drive.	Parsonsh	ure.	III) 2184	9	
		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Removal from	20b. Pla	ce of Dispo	sition (Name of natory or other plac	Committee of the Commit	Date		tion - City or To		
permit. Pages Department of I Important: If Ite any Injury or or		4 Donation 5 Other (S)	pecify)	Crem		ofDelma:		0-2007	Delm	ar, Del	.aware	
Dermit Depart Import any In		21. Signature of Funeral Service	icensee 11			. Name and Addres		Bounds Fu				
40240	-	23a. Part1. Enter the disease, or	complications that	aused the death	70	)5 E. Mai	n_Street	Salish	ury,	MD 2180	Approximate	
Physician // Medical Examiner with sicien and the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, reading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Hepun (or as a conseque (or as a conseque (or as a conseque	nos off.	Sure Bress	Carrel					
the death certific by the attending pi ached for use as t	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ ¶o 9 □ Unknown	1 Live	tcome of pregnand birth 2 ∏Fetal d nant at time of dea lown	leath 3	Ectopic pregnancy Other (specify)			230	d. Date of detive Month	4	ear
uires tha signed i	d by P	Part II. Other significant condition	ns contributing to d	leath but not result	ing in the ur	nderlying cause give	en in Part I.	23e. Did to	_	contribute to the		nknown
sician: The law require certificate has been si irrector, page 2 should t	Completed							24a. Was autop perfo	an :	24b. Were auto prior to co- death?	psy findings a npletion of ca	vailable luse of
	ပို	25. Was case referred to medical	_				36 Blace of Do	1 ☐ Yes eath   Check only o	2 No	1 🗌 Yes	2 No	
/sicia	0 8	examiner?	Hospital:	fnpatient 2□El	R/Outpatien	t 3 DOA Othe	er: 4 Nursing		7	Other (Specif	v)	
ding Phys	T :u	27. Manner of Death	28a. Date		8b. Time of	28c. Injury Work	at	28d. Describe h			,,	
ath.	atio	1 Auturat 5 Pendin 2 Accident investig	ation	,,	,ory		Yes 2 □ No					
or Atte	ertification;	3 ☐ Surcide 6 ☐ Could r 4 ☐ Homicide determ	ined 288. Place	of fnjury - At homing, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tox		Vumber or Rura	I Route Numb	oer,
urs af	O											
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the Examiner: On the b and man	e best of my knowl basis of examination oner stated.	ledge, death in and/or inv	occurred at the time restigation, in my of	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) ar date and pl	nd manner as si ace, and due to	tated. the cause(s)	
To th within To th compl	₩	29b. Signature and title of certified	2			29c. License				signed (Month,		
an i		N X	AN	1		Dur	50614		No	rember	20, 20	07
1 gar		30. Name and address of person	who completed cau	se of death (Item 2	23a) (Type,	Print)						
Box .		Unrale	2 Jarrae	mo 1	205	Print) Pembers	1dr Su	ti 101	Salis	bery p	s 21	108
St Regis	tate trar	31. Date filed (Month, Day, Year)  NOV 2 0	2007	Registrar's Signatu	ге	all )		•		)		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Jovember 18,200 /Medical Aa. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/14/1934 9. Birthplace (State or Foreign Country) Maryland 6. Sex Age (In yrs. last birthday Funeral Days Months Hours 1 □ M 2 📉 F Director 220-32-9858 73 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; if Item 27 is marked other than "natures!" or home notices. 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 408 Morgnec Apt 103 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ Specify 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Presser Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Spencer Ida Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Elk Chase Dr. Elkton, MD 21921 Chevelle Isaacs/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State njury or 11/28/2007 Janes Cemetery Chestertown, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Purperal Service Licensee 22. Name and Address of Facility any Chestertown, MD Bennie SmithFuneral Home Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ArteroSchertic Cardio Vascular Dispose 8 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the t as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3₺ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed? 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 X ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

NOV 2 1

32. Regis

ar's Signature

			For State Registrar	State	of Marylan		artment of H		Mental Hygi Re	ene g. No. 20 (	07 39235
	Dh		1. Decedent's Name (First, Middle	e, Last)					2. Date of Death Month		3. Time of Death
	Physici /Medi		KYOKO M. BRAWL						NOV.	21 2	007 02:17P <sup>M</sup>
,	Examir	ner	4a. Facility Name (If not institution	_	ımber)		4b. City, Town, or	r Location of Deat ERTOWN	h	4c. County of <b>KENT</b>	Death
	Funeral		CHESTER RIVER  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		. Birthplace (State or Foreign
	Director		219-54-8807	1 □ M 2 <b>X</b> F	75	Yrs.	Months Days	Hours Min.	(Month, Day, 03/21/19	32	JAPAN
	and ww		Usual Residence of Decedent  10a. State 10b. County	-	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Marylan I-f show fied at	tor	MD KENT		R	OCK HA	LL				1 XYes 2 □ No
	th the or 28a e noti	Director	10e. Street and Number				10f. Zip Code		10	9. Citizen of Wha	at Country?
	ath wi		21142 ROCK HAL				21661			USA	
730	d within 72 hours after death with the Maryland glene. I'r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	Armed F	2 <b>X</b> No		Vas Decedent of H f Yes, specify Cuba 1 □ Yes 🌠 No	ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		American Indian, White, etc.
12-003p	72 hou natura ilcal E	eted	15. Deceden	t's Education	)	16a. Deced	dent's Usual Occup- kind of work done of	ation	rkina 1	6b. Kind of Busin	ness/Industry
7	rithin 7	Completed	Elementary/Secondary (0-12)	<u> </u>	(1-4or 5+)	life. L	DO NOT use retired	during most or wo	King	OTHE HOM	172
7	75 75 = +4		12 17. Father's Name (First, Middle,	l ast)		HOMEM	AKER	18. Mother's Nar	ne (First, Middle, M	OWN HOM	<u>  E</u>
and	ld be filed ental Hyg ked othe ic event,	To Be	MICHIO MIURA					ITO KON			
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic	-	19a. Informant's Name/Relations	hip (Type. Print)		1	-		ural Route Number,		ate, Zip Code)
, M	and 2 ealth a n 27 I		HERBERT BRAWLEY	/HUSBAND				ROCK HALI	L,MD 2166		
altimore	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition  1		n State	cemetery, cirer		NOV.	25, 2007	ROCK HA	
Dall	Depart Depart Import any in	di d	21. Signature of Funeral Service	Helfe	nbein	$O \mid 1$	30 SPEER	RD. CHES	STERTOWN,	MD 2162	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		MOHON		7515		-		3 years
	Examiner			,	(or as a conseq 406	1	om Auc	Lun Tin	tra celly	10,00	34000
l,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D	(or as a conseq		///		10-1 0-119	PIVE	700
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
8/80,	be ex ician a burial			Due to	(or as a conseq	uence or):					
00	ficate physis the	edical		d							
O. BOX	w requires that the death certificate been signed by the attending physishould be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	1 ☐ Live	utcome pf pregna birth 2  Feta prant at time of d nown	al death 3□	Ectopic pregnancy Other (specify)	1		23d. Date of Month	·
Ţ.	that the post of t		Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contrib	ute to the cause of death?
cords	quires in sign	q pe	HTN; GER	Di Hya	othyro	id , C	hronic Be	ck Pail	1 □ Ye	s 2 No 3	☐ Probably 4 ☐ Unknown
ວ	> 9 70	Completed by		, ,	Ö,				24a. Was an	24b. We	ere autopsy findings available or to completion of cause of
Ē	The ate ha	Com							perform	ed? dea	ath? Yes 2 No
N II G	iclan: Sertific ector,	Be	25. Was case referred to medica examiner?	Hospital:			Oth	or:	ath (Check only one		
Ç	Phys rthis ral dir	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date	-	ER/Outpatien		4 Nursing F	lome 5 ☐ Resider		
5	th. th. After	tion	1 Natural 5 Pendin 2 Accident investig	9 (Mo.	nth, Day Year)	Injury	Worl	k? Yes 2 □ No	200. Describe not	w injury occurred	
VISION	Atter r deal ector by the	ifica	3 ☐ Suicide 6 ☐ Could in determine	ined   28e. Plac	e of injury - At ho ding, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number	or Rural Route Number,
5	tal or rs after al Dir	Certification:	4 Dilomoido	Dulk	aling, etc. (Opecin	y/ 			City or Town,	Jiale)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has: completely filled in by the funeral director, page 2	edical	(Check only 2 Medical one)	Examiner: On the and ma	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	vestigation, in my o	pinion, death occ		te and place, an	d due to the cause(s)
)	Mit To	M	29b. Signature and title of certifie	an)			Doc	e number 95099	I	d. Date signed (	Month, Day, Year)
			30. Name and address of person	a mal mo	1000	7	( 1	7/201	rtown	ma a	11.00
	Sta	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	or Ou	1) 5]. (	reste	HOWN	1111) 2	-1620
	Registi		NOV 2	6 2007	Beere	K A	goods)				
DHI	MH 17 Rev 1/2	001	NUVA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 2017 ovember ONNIE /Medical 4a. Facility Name (If not institution, give street 4b. City, 4c. County of Death **Examiner** (0m10 Birthplace (State or Foreign Country) last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 5 1 M 2 □ F Director 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? Of Zip Code Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Inportant: if them 27 is marked other than "natural", or items 23a or any injury or other traumatic event the Mandal-Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Dr No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify. Specify: B 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a\_Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O(OmoKe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location 1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 3 ☐Removal from State Con Accomac 22. Name and Address of Facility Bennie Smith Fune-al Hom 5 Other (Specify) Cignature of Fune 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Poconoka Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andio vilsonhi lerotro **Physician** wosc YEMS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) Division or Vital Records. P.O. | ☐Yes 2☐No the 9□Unknown 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 1 | Inpatient 3□ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21 O

BA5

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 6 2007

Etherton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

150 E. Corroll St.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** James Walter Butler, Sr. 6:07 РМ 18. 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing Home Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 28, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 □ F Yrs. 61 213-44-5503 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland St. Mary's Bushwood Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 7 20618 IISA 22390 Chickahominy Road Funeral th and Mental Hygiene. 7 Is marked other than "natural", or Items ; traumatic event, the Medical Examiner mu 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Security Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Helen Bowman ဥ Aloysius Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a t: If Item 27 Is y or other trae James Walter Butler, Jr. / Son 419 Dogwood Drive, Lusby, Maryland 20657 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 24, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 2007 22. Name and Address of Facility 21. Signatule of Funeral Service Licensee Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the ceath shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9□Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part) 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 2□ No LOCUIC 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after the Funeral DI completely filled in Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Irving Street NW #415 Washington DC 20010

32. Registrar's Signature

License number

Yudh Gupta, M.D.

29d. Date signed (Month, Day, Year)

u

se i	Type of Print in Black indelible link. Ensure All Copies Are Le	egı	DI	e
	State of Maryland / Department of Health and Mental Hygien	J	0	7

			For	State	of Mary	yland	/ Depa	artment	t of H	ealth a	and M	lental Hy	giene	2007	39239
_			For State Registrar				Cei	rtificate	e of L	Death		F	Reg. No.		
Phy	sicia	ın	Decedent's Name (First, Middle									2. Date of Dea Month	Day		3. Time of Death
/M	edic	al 🗄	Dustin D. B  4a. Facility Name (If not institution		umbor)			4h City	Town or	Location of	of Doath	Nov.	19	2007 County of Deat	4:30 AM
Exa	ımin	er	National Insti	_		th		Beth			n Death			ontgome	
Fune	ral	T.	5. Social Security Number	6. Sex			st birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt	<u> </u>		hplace (State or Foreign untry)
Direc			482-92-9954	1⊠M 2□F	30		Yrs.	MOTUS	Days	Houis	WIII I.	04 09	777	Iow	a
and	4		Usual Residence of Decedent  10a. State 10b. County		10	0c. City,	Town or Lo	cation							10d. Inside City Limits
Maryl -f sho	o Dai	tor	IA Black	hawk		Ced	arfal	1s							1XTYes 2 ☐ No
h the	Boll	Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What Co	untry?
uth wit	nsi D	la l	1718 Man Dalay	Dr. #2					613					USA	
er dea		Funeral	11. Marital Status	12. Was De Armed F	orces?	er in U.S.	. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	ispanic Ori ın, Mexicai	gin? (Spo 1, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>	
rs afte	Xam	by F	1 XNever Married 2 Marr 3 Widowed 4 Divorced	led 1 1 Yes If Yes, G Year or	2 🔼 No Sive Dates:			1□Yes 2	2 <mark>ऄ</mark> No	Specify:				Specify: Wh	Lte
d vithin 72 hours af giene.	L CS		15. Deceden (Specify only highe	t's Education	()		16a. Deced	dent's Usua	al Occupa	ation	t of work	ina	16b. Ki	nd of Business/	Industry
Lithin 7 ithin 7 ithin 7 ithin 7 ithin 7	Med	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		life. l	kind of wor DO NOT us	se retired	)	t of work	ing			
led w Hygier	<u>.</u>		17. Father's Name (First, Middle,	4 y	rs.		Unen	nploye	ed	18 Mothe	ar'e Name	e (First, Middle,		ne Surnama)	
Viano  Viano  Vid be file  Mental Hy  arked oth	φ 4	Be	Unknown	Lasi)								Baker	Maldell	Surnamej	
ary, shoulk nd Me mark		ဥ	19a. Informant's Name/Relations	hip (Type. Print)			19b. Mailir	ng Address	(Street a			al Route Numbe	er, City o	r Town, State, 2	Zip Code)
and 2 st alth and 27 is n			Deborah_Wymore	/Mother		-	2508	Union	n Rd	. #20	1 Ce	dar Fal	ls,	Iowa 50	0613
IOFE, MATYIATIO ZIZID-UU3O  ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If them 271 is marked other than "natural", or items 23a or 28a-f show the frains and enough the Madical Exeminar muter handling as			20a. Method of Disposition 1 ★Burial 2 ☐ Cremation		n State	20b. Pla	ace of Dispo metery, crei	sition (Nam matory or o	ne of ther plac	e)	ı	Date	20c. Lo	cation - City or	Town, State
Daltimor Department of Important: If it	h		4 ☐ Donation 5 ☐ Other (S	pecify)			lar Va				11-2	8-07	Ceda	r Falls	Iowa
permit. Pages 'Department of H	once.		21. Signature of Funeral Service	Licensee	00	Gard	ien 22	2. Name an 4217	d Addres	S of Facili	<sup>ty</sup> Ma. N.W	rshall' • Washi	s Fu	neral H	ome
			23a. Part T. Enter the disease, or shock, or heart failure. List	complications that	caused the	e death.								п, р.с.	
Physici	an		Immediate Cause (Final		each line.										Approximate Interval Between Onset and Death 2 Years
/Medi	cal		disease or condition resulting in death)	а.	o (oras a c										Congenital 28 Years
Examir	33	_	Sequentially list conditions,	b			nuloma	atous	Dise	ease					28 Years
ped tied	<u></u>	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duak	(or as a e	ronsaqua	inea offic								
execut and and	ק ק ק	Examiner	that initiated events resulting in death) Last	c	o (or as a c	onseque	ence of):								-
te be ex	and a	cal		d											
rtificat ing phy	200	Med	IF FEMALE:										- 1		
ath cer attendin	on in	Physician/Med	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal	death 3	□Ectopic pr		,				23d. Date of de Month	ivery Day Year
the de	nen l	ysic	1 Yes 2 No 9 Unknown	4⊟Preg 9⊟Unk	gnant at tim nown	ne of dea	ath 5L	Other (sp	ecity)		-				
that the red by	neig		Part II. Other significant condition	ons contributing to	death but n	not result	ting in the u	nderlying ca	ause give	en in Part 1		23e. Did to	obacco u	use contribute to	the cause of death?
law requires t as been signe	nin Di	ed by	Renal Dysfunc	ion								1 🗆 🗅	res 2	X No 3□P	robably 4 □Unknown
taw re	Z SIIO	plet	Cytomegalovir	ıs Infect	ion							24a. Was	an	24b. Were at	utopsy findings available completion of cause of
The The Sate h	page	Completed	Respiratory A	cidosis								perfo 1∐ Yes	rmed?	death?	_
VITAL ician:	ecior,	Be	25. Was case referred to medica examiner?	Hospital:	/				Othe	or.		h <i>(Check only o</i>			
Phys r this	<u> </u>	<u>۲</u>	1 ☐ Yes 2 ☐ No  27. May er of Death		Inpatient of Injury		R/Outpatier 28b. Time or			4 🗆 IVI		me 5 Residence 128d. Describe I			cify)
lor Attending Phy after death.  Director: After this in by the funeral of		tion	Natural 5 Pendin	y ·	nth, Day Y	rear)	Injury	М	8c. Injun Worl 1 □	k? Yes 2. ☐					
VISI	Dy ulk	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined   Zee, Plac	ce of injury ding, etc. (	- At hom (Specify)	ne, farm, str	eet, factory	, office			28f. Location (S City or Tox			ural Route Number,
italor ral Diagram		Se									10				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and executed the property of the transport of the physician and promoted the physician and promoted the physician and promoted the physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician and physician physician and physician physician and physician and physician physicia	areny III	Medical		g Physician: To the Examiner: On the		kaminatio									
o the	ad lo	Mec	29b. Signature and title of certifie		Janet States	u.		290	c. License	e number			29d. Da	te signed (Mon	th, Day, Year)
4			Den At 4	tolo	2	M	)	Ma	ary1	and D	0033	308	1	Nov. 19	, 2007
0	/		30. Name and address of person	,	use of deat	th (Item 2									
To X			Harry L. Ma	lech	Dogietror'-	e Sianat			Dri	ve, B	ethe	sda, Ma	ry1a	and, 208	392
Reg	Sta gistra		NOV 2 1 20	07 Same	Tiegistiai s	#.	Sperk	w							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) NOV 2 1 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cynthia E.W. Booker November 17 2007 10:42 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Community Hospital Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 09/28/1961 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) 1 □ M 2 🖺 F 579-74-4540 46 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11506 West Branch Drive 20774 TICA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 N Married Black 1 ☐ Yes 2 🖾 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Contract Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Waller Mildred Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory A. Booker/Husband 11506 West Branch Dr., Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ICremation 3 ☐ Removal from State Fort Lincoln Crematory 11/21/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrythmia disease or condition resulting in death) Due to (or as a consequence of): Pulmonary Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Congenital Cardiomyopathy Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Alcohol Abuse 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Partial Small Bowel Obstruction performed? death? 1 ☑ Yes 2 ☐ No 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1' Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 M Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be signed by Division or Vital Records, has

Physician

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f show notified at

"natural", or items 23a or 7

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, til

**Physician** 

/Medical

Examiner

Completed by Physician/Medical

Be

၉

Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

72 hours after death

Maryland 21215-0036

Baltimore,

Director

by Funeral

Completed

Be

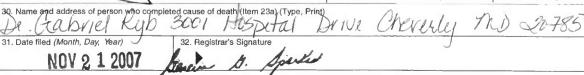
filled in by the funeral To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) NOV 2 1 2007



1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Anna K. Cugler 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 542136414 RAINSIUM REGIONAL Niconico If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
Dec. 24, 1926 Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 80 222-12-1882 Director New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNO Director Maryland Wicomico Delmar 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9183 Bi-State Boulevard 21875 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify: Specify. ğ 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home and Mental Hygic is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be permit, Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked of any Injury or other traumatic ew Peter Kerekesch ೭ Mary Kerekesch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, DE Mary Cugler Loscomb (Daughter) 28022 Park Lane 19956 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) St. Stephens Cemetery Nov. 24, 2007 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause mal disease or condition resulting in death) CARDIOMYOPATY **Physician** YEARS /Medical Due to (or as a consequence of): Examiner 5405 Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Exami burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ģ Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the be detached 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ⋧ 1 Yes 2 No 3 Probably 4 Unknown cate has been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No Hospital 3□ DOA 1 X Inpatient 2 ER/Outpatient 2 To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D., Ph.D merkot 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MO 31. Date filed (Month, Day, Year) NOV 21 State NOV 2007 Registrar

			Please	Type or Print in BI			-		20212
			For State	State of Maryland	Certificate of			_ 0 0 .	39243
			Registrar  1. Decedent's Name (First, Middle, La	net)	Certificate of		Reg. Date of Death	No.	3. Time of Death
- 6	Physici /Medic		HELEN Ving	70	Nish		Month	B - 07	11: 30 AM
	Examin	er	4a. Facility Name (If not institution, giv		11 (	or Location of Death		4c. County of Death	m
100	Funeral		5. Social Security Number 6. S		st birthday) If Under 1 Yea	r If Under 24 Hrs. 8.	Date of Birth (Month, Day, Ye		place (State or Foreign
25	Director		215 - 20 - 1036 Usual Residence of Decedent	1□M 2×F 89	Yrs. Months Days	Hours Min.	4-22-	1918 MA	eyland
	aryland show	_	10a. State 10b. County	1 . 1	Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma 8a-f s	ecto	MARYLAND Wicom	100	-brow		100	Citizen of What Cour	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Ea.	Funeral Director	10e. Street and Number 7829 Rockaw	nalkin, Road	10f. Zip Code	30	Tog.	USA	
	r dea	nner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Specif ban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 🖎	Specify:		Specify: 3	ACK
5-0036	2 hour atural cal Ex	ted t	15. Decedent's E	ducation	16a. Decedent's Usual Occi	upation		. Kind of Business/In	dustry
215	thin 7 e. an "n Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		e during most of working ed)		11=	
2	led wi	Con	08		Domesti	18. Mother's Name (F	First Middle Mair	NONE	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last	Qu.		MARY	Wilson		
ΪŽ	should be f and Mental h s marked of umatic ever	2	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Stree			ty or Town, State, Zip	Code)
_	1 and 2 s Health ar em 27 Is	1	ARDEEN Rhock-TA	Wor DAUGHER	159 NINA L	ANG FRUITA	Nd Md	21826	
ore,	es 1 a of He filtem		20a. Method of Disposition  1≱Surial 2 ☐ Cremation 3 ☐	cer	ce of Disposition (Name of metery, crematory or other pl	,		. Location - City or To	) [
Baltimore,	. Pages tment of h tant: If ite jury or o'		4 □ Donation 5 □ Other (Special	(v) Sp	ring hill	11-24	-07 H	EDRON, N	) neyland
Ball	permit. Page Department or Important: If any Injury or once.		21. Signature of Funeral Service Lice	Stewart	22. Name and Add		821 WEG	Rd. Sal	c Od 21801
	ell.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the death.				1011	Approximate Interval Between
16	Physician		Immediate Cause (Final disease or condition	CLIALLE	ue arent				Onset and Death  MU 5
	/Medical Examiner		resulting in death)	Due to (or as a conseque	nec of):	derviti Ca	1	1 Duis	
	Lammer	<u>.</u>	Sequentially list conditions,	weice onen	765				
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque					
60,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):				
376	ate be nysicia he bu	Physician/Medical	•	d					
x 687	feath certificate t attending physic I for use as the b	Med	IF FEMALE:	00-16					-
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnand  1 Live birth 2 Fetal d  4 Pregnant at time of dea	leath 3 Ectopic pregnan	су		23d. Date of deliver	ery Day Year
P.O.	that the dened by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown					***
	8 F 9	by Pł	Part II. Other significant conditions		Did tobacco use contribute to the cause of death?				
Vital Records,	w require been sig should b	ted					1 Tyes	2 No 3 Probably 4 Unknown	
3ec	has b	Completed					24a. Was an autopsy performed	prior to co	opsy findings available Impletion of cause of
a			25. Was case referred to medical			OC Disease Frank //	1□ Yes 2☑	No 1 ☐ Yes	2□ No
5	Physician: this certificatal director, I	o Be	examiner?	Hospital: 1 Inpatient 2	R/Outpatient 3 □ DOA O	26. Place of Death (6 ther: 4 ☐ Nursing Home		e 6 □Other (Specia	fv)
1 O.	dlng Phy h. After thi funeral c	n: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	28c. Inj Injury W		d. Describe how i		
Sion	Attendlr death. ctor: Af y the fur	atio	2 Accident investigation	n	M 1[	Yes 2□No			
Division	or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined		e, f <i>a</i> rm, street, factory, office	e   281	City or Town, S	t and Number or Rur. tate)	al Route Number,
	spital ours a neral filled			nysician: To the best of my knowl					
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examone)	miner: On the basis of examination and manner stated.	on and/or investigation, in my	opinion, death occurred	at the time, date	and place, and due t	o the cause(s)
	To the track to th	Z	29b. Signature and title of certifier		29c. Licer	nse number	29d.	Date signed (Month,	Day, Year)
	la		Smuld M	· livers, NO	01	0688		11/20/0	7
	In		30. Name and address of person who	completed cause of death (Item 2	(3a) (Type, Print)	IN 111 21	804 /	Donald M.	WOOD MX)
	Sta	te	31. Date filed (Month, Day, Year)	and manner stated.  LIVEN, NO  completed cause of death (Item 2  N S/IMF DIA)  32. Restrar's Signatu	re President	INT, INCH NI		- Complete	110)
	Registr		NOV 2 0	2007 Jane	the specific				

			1 - For State Registrar	State of	Marylaı		artmen rtificat			Mental Hy	Reg. No.	07	39244
	Physici	an	Decedent's Name (First, Middle							2. Date of De Month	Day	Year	3. Time of Death
9	/Media	cal	EARL R. 4a. Facility Name (If not institution	CONRA			ah City	Tour or	Location of Dea	Novemb		2007 by of Death	6:25 P M
	Examir	ner	Anne Arundel				40. City,		Annapoli			•	rundel
	Funeral Director		5. Social Security Number 197–26–0491	6. Sex 1⊠M 2□F	7. Age (In yrs 72	. last birthday) Yrs.	If Under Months	r 1 Year	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign ntry) insylvania
	pur *		Usual Residence of Decedent  10a, State 10b, County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	ne Maryla 8a-f ehor	Funeral Director	Maryland Anne	Arundel					ersvill	e			1 ☐ Yes 2 🔯 No
	with the sa or 2	Dir	10e. Street and Number 111 Solomons R:	idge Court			10f. Zip	Code	21108		10g. Citizen of	S.A.	ntry?
	death	nera	11. Marital Status	12. Was Dece		J.S. 13.	Was Dece	dent of Hi	spanic Origin? (S	Specify Yes or No to Rican, etc.)		ice - Ameri	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-1 ehow he Medical Examiner must be notified at	Ď	1 ☐ Never Married 21☑ Mar 3 ☐ Widowed 4 ☐ Divorced	It Van Chu	2 □ No		1 ☐ Yes		Specify:	to ricall, etc.)	Spec	ack, White,	hite
5-0	72 h	etec		t's Education st grade completed)		16a. Dece	dent's Usu kind of wo DO NOT u	rk done a	turing most of wo	rking	16b. Kind of I	Business/In	dustry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	_	wner	se reurea,	,		Aut	o Rep	air
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other then "natural", or Items 23s or 28s-1 ehow any injury or other treumatic event, the Madical Examiner must be notified as once.	To Be Co	17. Father's Name (First, Middle, Last)  George S. Conrad  18. Mother's Name (First, Middle, Maiden Sun Kathleen M. Cain							, Maiden Suma			
Maryland	id 2 shou lth and M 27 le mar treumat		19a. Informant's Name/Relations Joan L. Conrac	1.1.21		1	_			ural Route Numb			
	S 1 and Heal of Heal		20a. Method of Disposition		1	Place of Dispo cemetery, crer	sition (Nai	me of		Date	20c. Location		
Ē	Page nent c ant: If ary or		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (S		Ba	altimor	e Cre	emato	ry 11/3	20/2007	Baltim	ore,	Maryland
Baltimore,	permit. Depertr Imports eny inju		21. Signature of Funeral Service	Licensee						John M. ester St			al Home , MD 21401
.O. Box 68760,	Cate be executed by sicien and by sicien and physicien and the buriat-transit the buriat-transit was a second of the private o	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Ch line.  ASTAT  or as a conservation as a conservation as a conservation as a conservation as a conservation as a conservation.	quence of):				OTHELIP			Interval Between Onset and Death
	The law requires that the death certifical ate has been signed by the ettending phypage 2 should be delached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   23d. Date of   23d. Dat								ery Day Year		
Records, P.	luires that n signed b	þ	Part II. Other significant condition HYPERTENSION	ons contributing to dea	ath but not re	sulting in the u	nderlying o	cause give	en in Part I.	1	tobacco use coi Yes 2 □ No	ntribute to t 3 ∐ Prot	he cause of death?
ō	aw requir is been si 2 should	Completed	CORONARY AN	CORONARY ARTERY DISEASE 24a. Was an autopsy						an 24b	24b. Were autopsy findings available prior to completion of cause of		
Ä	eician: The law certificate has b irector, page 2 s	E O	AORTIC VALV			tatus p	est	reple	ermen	perfe	ormed? 200 No	death?	2 No
Vital	cian: ertific actor,	Be (	25. Was case referred to medica examiner?					Tou		ath (Check only	one)		
of	ding Physician: h. After this certifica funeral director, I	P	1 Yes 2 No			ER/Outpatien			4 INUISING	Home 5 Res	idence 6 🗆 Ot		<b>5</b> y)
no	After fune	tion	1 Natural 5 ☐ Pendir		, Day Year)	Injury	м	28c, Injury Work 1 □ 1	al ?? ∕es 2.⊟No	200. Describe	now injury occu	mea	
Division	I or Attendi after death Director: A I in by the fu	Certification:	3 Could not be			at home, farm, street, factory, office 28f. Locat					ocation (Street and Number or Rural Route Number, ty or Town, State)		
-	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C		ng Physician: To the b Examiner: On the ba and manne	sis of examin								
ų.	within To th compl	Me	29b. Signature and title of certifie	r /)			29	c. License		105	29d. Date sign		
	B-1x	M	Smun	lost	MD			NC	062	705	11-18	,-21	00 /
1	D. Con		30. Name and address of person	who completed cause		m 23a) (Type,	Print)	0	116 De	FENCE	HWY	Ann	apolisMD2140
	Sta	te	LUCINDA:  31. Date filed (Month, Day, Year)	22 08	oietrar's Sign	aturo			,,,,,		1.	/ \////	10490
	Registr		NOV 2	0 2007	alless a	# 4	hard!						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2007 39245 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Herbert Millard Collins /Medical November 25, 2007 2:35 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 26371 Fielding Road St. Mary's <u>Hollywood</u> If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1X M 2□ F Hours Director 097**-**16-1790 85 07/27/1922 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 X No Maryland | St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26371 Fielding Road Funeral 20636 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Laboratory Technician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Paul Collins Lillian Millard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Vetter/Daughter 26371 Fielding Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 11/28/2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive month Due to ( as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DUE to (or as a consequence of) beles Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Prostalic 1 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 2 ER/Outpatient 3 DOA 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred

the death certificate be executed attending physician and for use as the burial-tran Box 68760, as the l signed by the at d be detached for P.O. I or Vital Records. been has To the Hospital or Attending Physi-within 24 hours after death. To the Funeral Director: After this of completely filled in by the funeral dir Division

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or; any Injury or other traumatic event, the Medical Examiner must be n

/Medical

Examiner

altimore, Maryland 21215-0036

the

at

must be notified

Certification: 1 Natural 2 Accident 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29c. License number A0032651.

State Registrar

31. Date filed (Month, Day, Year) 7 2007

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39246 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Margaret Η. Chambers November 19, 2007 9:48 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 5,1925 9. Birthplace (State or Foreign Days Hours 218-12-5866 82 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Camp Springs 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7504 Harrison Lane 20748 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 No White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hersick Annie Petrun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa H. Chambers-Riskin P.O. Box 857, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Joseph S Catholic 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/2007 4 Donation 5 Dother (Specify) Midland, MD Church Cemetery George and Attended Fully Frank Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Plant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Im mary edama Due to (or as a con equence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence f): 101 100 Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform rmed? 2 ☑ No 2 No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

၉

**Funeral** 

Director

ms 23a or ? must be r

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine attending physician for use as the buria Physician/Medical ed by the a been signed by should be detact þ Completed funeral director, Be Certification: To this After after death filled in by the within 24 hours a To the Funeral I

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Hospital:

1 Inpatient

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No 1 TYes 27. Mayner of Death 1 V Natural 2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 ☐ Pending investigation 6 Could not be determined

Date of Injury (Month, Day Year) Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifiet

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Chun, M.D. 100 Hospital Rd., Prince Frederick, MD 20678

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 2 1 2007 32. Registrar's Signature

death,

Hospital or

the

0

Division of Vital Records, P.O. Box 68760, 4 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death

3 6 Could not be Suicide determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie

29c. License number 29d. Date signed (Month, Day, Year)

OCME O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 27, 2007

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

			For State Registrar	State of Mary		artment of		nd Men		ne . <u>v</u> 2. ()	0.7	39248
	Physic	ian	Decedent's Name (First, Middle, La     Robert Lee	Devereaux	. C.				Date of Death Month DVember	Day	2007	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, giv		x Sr.	4h City Tourn	, or Location of		ovember		200 /	T:10 - W
	Examir	ner	26788 Rumbley F			Fairm		Death			nerset	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday		r If Under 2	4 Hrs. 8. E	Date of Birth Month, Day, Y			place (State or Foreign ntry)
	Director		218-40-5288	1⊠M 2□F 64	Yrs.	World S Day	3 110013	2	4/12/19	43		yland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation					·	10d. Inside City Limits
	Mary 9-f sh	tor	Maryland Worces	ster	Pocomo	ke City						1 ☐ Yes 2 🛣 No
	or 28	Direc	10e. Street and Number			10f. Zip Code			10g	. Citizen d	f What Cou	ntry?
	s 23e	rai	1944 Cedar Hall			218				USA	4	an Indian
<b>'</b>	172 hours after death with the Maryland "naturel", or Items 23e or 28e-f show dical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No	r in U.S. 13.	Was Decedent of If Yes, specify Cu	r Hispanic Orig iban, Mexican,	Puerto Rica	n, etc.)		ace - Americ lack, White,	
936	ours a	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🔣 N	o Specify:			Spec	cify: W	nite
5-0	"natu	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece (Give	edent's Usual Occ e kind of work don DO NOT use retii	upation le during most	of working	16	b. Kind of	Business/In	dustry
12	within iene. then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		esman	rea)			retai	i 1	
þ	be filed within 72 hours after death with the Marylan Ital Hygiene. Id othar then "naturel", or Items 23e or 28e-f show avant, the Medical Examiner must be recified at	BeC	17. Father's Name (First, Middle, Last	)	, bar	JUINATI	18. Mother	's Name (Fir	st, Middle, Ma			
ylaı		To	James Levin Dev				Win	ifred	Franci	s To	vnsend	<u> </u>
Maryland 21215-0036	2 sh and Is m		19a. Informant's Name/Relationship ( Brenda Sue Dever			ing Address (Stree 14 Cedar				-		
	1 an Heal am 2 thar		20a. Method of Disposition		Ob. Place of Disp	osition (Name of	!	Date			n - City or To	
ē	00		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			matory or other pa		11/201	1		bury,	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	nsee	2	2. Name and Add	ress of Facility	ral Ho	ome Pro	fossi	ional	Association
	20 E 29		Muchel A	Dean		DOT DU	OM HITT	Ra.,	Salisb	ury,	MD 21	804
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.					piratory arrest	•		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Me fa :		Co/0 ~	Can	ف				1 year.
	Examiner			b	risequerice orj.							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):							
8760,	sate be executed oblysician and the burial-transit	ical E		d	,							
9	death certificate e attending phys id for use as the	8	IS SEMALS.							T		-
Вох	death certifica attending ph for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death 3	⊒Ectopic pregnan	су			1	ate of delive	ery Day Year
P.O.	s that the de ned by the a e detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown	ofdeath 51	Other (specify)						,
	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death but no	t resulting in the t	inderlying cause g	gven in Part I.		23e. Did tobac	co use co	ntribute to th	ne cause of death?
ıd	w requires been sign should be								1 🗆 Yes	2 No	3 ☐ Prob	ably 4 Unknown
of Vital Records,	e taw re has be je 2 sh	Completed						_ [	24a. Was an autopsy		prior to co	psy findings available mpletion of cause of
a H	Th ate pag							1	performe 1 ☐ Yes 2 🔀		death? 1 ☐ Yes	2)200
Ζ	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	- 20 pg. 0			eck only one)			VACATION
٥٥	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	- regre	IL OLIDON	- INGIS		5 🗌 Residenc Describe how			HOME.
sior	Attanding ir death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	an injury		JYes 2 □ No	0				
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office	Э		ocation (Stree City or Town, S		nber or Rura	I Route Number,
	To the Hospitel or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	dical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my	y knowledge, deat	h occurred at the	time, date and	place, and d	lue to the caus	e(s) and n	nanner as s	tated.
	To the Ho within 24 To tha Fu completel	Ψ.	one)	niner: On the basis of exa and manner stated.	mination and/or in			occurred at				` '
	To With	Σ	29b. Signature and title of certifier	2/: N	·D.		rse number			•	ed (Month,	*
	10th	1	30. Name a * address of person w	completed cause of death	(Item 23a) (Type	Print)		- cne			19.0	
	V 0		Jones E. MART,	N M, D.	145 E	. Cerrol	15+	, 50.	te A-	1 3	c/.36	Urz, MD
	Sta		31. Date filed (Month, Day, Year)	\$2. Registrar's S	Signature		<u>-</u>	7	7		•	1
	Registr	ar	NOV 21 2007	General 1	J. GOBA							

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registr

2007

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2007 Physician 20, Mary Katherine Darden Nov. 1:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilcrest Hospice of Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months 1 M 2 XF 216-09-0172 1918 Pocomoke City, MD 89 Jan 16, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 ☐ Yes 2X No Anne Arundel Edgewater Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a the Medical Examiner must b 21037 USA 4170 Carrs Ridge Road Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify 3 Nidowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ייי איונחור. יי איונחור אייי איונחור. ז' 27 Is marked other than "יי ז' traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 Administrative Support 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any liqury or other traumatic event once. Be Iva Jane Moore Samuel T. Moore, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1509 Castle Cliff Pl., Silver Spring, MD Marilyn M. Walsh - Niece Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 11/23/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final veek **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Por Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? has page 2 this certificate 1∐ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 1 Inpatient funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

6701 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bin (

us

November 20, 2007

harles St. Balto. Md 2020x

07-08937 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Albin John Derecki State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Year November 18, 2007 Albin John Derecki 1720 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Ft. Washington 12400 Arrow Park Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours 359-16-4688 Director 82 1 X M 2 F April 11, 1925 Country) Illinois Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1 Yes 2 XXXIo 28a-f show Maryland Prince George's Ft. Washington 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12400 Arrow Park Drive 20744 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 XX Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XX Yes White Yes, Give Year 1946-1963 Yes 2 XX No specify: Specify: Widowed Divorced permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 Military 12th United States Air Force 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Derecki Josephine Be Dyngus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Derecki/Wife 12400 Arrow Park Drive Ft. Washington, Md. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State 12/05/2007 Arlington Nat. Cemetery Arlington, Virginia Donation 5 Other Specify 22. Name and Address of Facility ture of Funeral Service Licens George P. Kalas Funeral Home P.A. also 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Approximate Interval 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Compressional Asphyxia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical Funeral Director: After this certificate has been signed by the attending physician stely filled in by the funeral director, page 2 should be detached for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Remote cerebral infarct Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes 2 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other; Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA Inpatient 2 No 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject became compressed under bed FOUND: Natural 1 Yes 2 ✔ No 5 Pending Nov 18, 2007 1707 hrs 2 🗸 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 12400 Arrow Park Drive, Ft. Washington, MD determined (Specify) Residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the |

State Registrar

Patricia Aronica-Pollak MD.

29b. Signature and title of certifie

Assistant Medical Examiner 32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 19, 2007

and manner stated

enuch 30. Name and address of person who completed cause of death (Item 23a) 07-09099 Jo

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

ohn Evancho		-For State of Maryland / Department of Health and Mental Hygiene -For State Certificate of Death Reg. No.								
Physician/		legistrar 2 Date of Death 3. Time of Dea								
ledical Examine		John Evancho November 24, 2007								
À.	4	Civista Medical Center  La Plata  Charles								
Funeral Director		5. Social Security Number  343-54-4352  6. Sex  7. Age (In yrs. last birthday)  1								
any		Usual Residence of Decedent         10d. Inside City Limits           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits								
8.1		Maryland Charles Waldorf 1 Yes 2 X No								
tor 28a-f show iffed at once.		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								
th the l 23a or notifie		2701 Bismark Street 20603 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								
15-0036  filed within 72 hours after death with the Maryland Hyggene, 4 other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once	nuer	1 Never Married 2 Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Neve								
s after d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: WILLE								
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		Elementary/Secondary (0-12) College (1-4 or 5+)								
036 ithin 72 ne.	Completed	/ Project Leader U.S. Government								
Hygie d other		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Norah Nolan								
21215-0 ould be filed w I Mental Hygic s marked othe ic event, the N	o Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
O 4 2 2 2		Cathy L. Evancho/Wife  2701 Bismark Street, Waldorf, MD 20603  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State								
		1 W Burial 2 Cremation 3 Removal from State Arlington National Com								
Baltimore, permit. Pages I an Department of Hes Important: If ite injury or other tr	ŀ	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Parin field—Echols F.H., P.A.,								
Ba perm Depa Impe	1	30195 Three Notch Rd., Charlotte Hall, MD 20622								
Physician 'M. dical		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death								
kaminer	1	Immediate Cause (Final disease or condition resulting in death)  Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):								
		Sequentially list conditions, b								
	Examiner	ff any live ding to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
ed nsit	Exal	events resulting in death) Last Due to (or as a consequence of):								
executed ian and ial - transit		d. UNPENDED AMENDED								
ox 68760, eath certificate be exe attending physician for use as the burial-	Ş  ¥	IF FEMALE: 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery Month Day Year								
Box 687( c death certificate the attending ple ed for use as the	cian	past 12 months?  4 Pregnant at time of death 5 Other (Specify)								
BOy he death the att	Physician/Medical	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?								
P.O. B res that the d signed by the be detached	ত্র	1 Yes 2 No 3 Probably 4 Unknown								
rds, require been si hould b	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of								
Vital Records, ysician: The law requirement in sertificate has been director, page 2 should	dwo	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								
Vital Reconstitutes and the confidence of the co	Be C	25. Was case referred to medical 26. Place of Death (Check only one)  examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other:  Nursing Home 5 Residence 6 Other:								
n of VII	ဠ	examiner / 1 V Yes 2 No								
OD O ending ath. or: Aft the func	tion	1 Ves 2 No								
Division of Vital Records, P.O. into or Attending Physician: The law requires that the rate death.  The law requires that the rate of the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	Medical C	29a. Certifier (Check only one)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  November 26, 2007								
ОСМЕ		30. Name and address of person who completed cause of death (Item 23a)								
		Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day Year) 32. Registrar's Signature								
Sta Registr		MANY 9 0 7807 & A. A.								
DHMH 17 Rev 1/200	01	ORIGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 11:45 AM DOVEMBER Wattie L. Elliott 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 ☐ M 2 🕱 F 1922 Burlington, N.C. April 10, 85 Director 577-34-5339 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at 1X Yes 2 No Upper Marlboro Maryland Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States "natural", or items 23a 20772 5605 South Marwood Blvd #422 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ∏Yes 2 M No f Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify. 3 Nidowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Licensed Practical Nurse</u> Private s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maude Hardy ပ Arthur Corbett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5605 South Marwood Blvd. #422 Upper Marlboro, Md 772 Department of Health a Important; If Item 27 is any Injury or other train Sharon L. Marshall / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of h 1 Burial 2 □ Cremation 3 □ Removal from State Nov. 21,2007 Laurel, Md. 4 □ Donation 5 □ Other (Specify) Maryland National 21. Signature of Funeral Service Licence 22. Name and Address of Facility Alexander S. P 5538 Mariboro Pikė/Forestville, Md. 20747 23a. Part X Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a conse mence of Examiner Sequentially list conditions, if a 4 leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ed by the a detached f 1 Ves 2 No Ö 9 Unknown ٣. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 1☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. and title of der 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 5

State Registrar

13

AMMAD. Lie

J-d706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9

32. Registrar's Sig

60

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 0910 A M 2007 wel trank /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner Viconico Hospice at the Salisbur If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 M 2 □ F 218-30-1165 72 Director 12/15/1934 Maryland Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 1 √Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 515 Druid Hill Ave. 21801 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than Caldabaugh Communications electronics technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be file f Health and Mental Hy tem 27 is marked oth Be Alta Genevieve Watkins Silvio Larrabee Franks permit. Pages 1 and 2 should Department of Health and Men 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26183 Bosch Lane, Hebron, MD 21830 Andy K. Franks/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition important: if it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/19/07 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Asso 501 Snow Hill Rd., Salisbury, MD 21804 oignature of Funeral Service Licensee ess of Facility
Funeral Home Professional Association Javie H. CFSP DOWNOON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARCINOMA Physician /Medical Due to (or as a consequence of): Examiner PROSTATIZ ARCINOMA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examine certificate be executed signed by the attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 ☐ Yes 2 ☐ 40 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? /es 2 has certificate 1□ Yes 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € 100 1 Phpatient 2 ☐ ER/Outpatient 3□ DQA ပ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4

State Registrar

DASTAL HOSPICE P.U BOX 1733 SALISMURY UND 21802 -HUMM WAR IS 31. Date filed (Month, Day, Year) 21

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend stem 20b per flog874 12-7-07vt and Mental Hygier@ 1 7

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 17, 2007 S. Green III November 11:14 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6904 Seneca Drive Snow Hill Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**⊠** M 2□ F Yrs Director 215-32-8474 87 6/8/1920 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show 27 Is marked other then "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Worcester Snow Hill Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 6904 Seneca Drive 21863 USA Funera 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Itel XYes 2 □ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: þ If Yes, Give Year or Dates: Navv 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4+ Physician Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dr. John S. Green Jr. Helen Cole ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6904 Seneca Dr., Snow Hill, MD 21863 Linda E. Green/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11-19-07 ' 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service See 501 Snow Hill Rd., Salisbury, MD 21804 Clendy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Physician 44 /Medical Due to (or as a consequence of): Examiner co (i) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that interest Due to (or as a consequence of): Examine certificate be executed burial-transit Causa (Disease or Irijunthat initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 2 🗷 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 5 desidence 6 ☐ Other (Specify) 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier YIVA 147094 NOW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M) 2/804 VATEGON GALISBUMY 14/5 shelv 5-DIV 1516~ 31. Date filed (Month, Day, Year) NOV 2 1 2 Registrar's Signature State 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 19, 2007 **Physician** Norma Peterson Greene 6:46 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Sept. 12,1918 If Under 1 Year I Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2**X** F 89 208-10-1423 Yrs. Missouri Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or **USA** 43 W. McKinsey Road Condo 108 21146 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 7 Is marked other than "natu traumatic event, the Medic... 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager DuPont 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dewey C. DeRuse Ollie May Dees ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 19a. Informant's Name/Relationship (Type. Print) Health an Department of Health Important: If Item 27 any injury or other tr Severna Park, MD R. Carleton Greene/Husband 43 W. McKinsey Rd. Condo. 108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 20, 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2007 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. gnature of uneral Service License Severna Park Funeral Home Severna Park, MD 21146 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as cause on each line. 1. Enter the disease, or complications, or heart failure. List only one Approximate Interval Between nset and Death Immediate r ause (Final disease of condition resulting in death) D575 Physiclan /Medical Due to (or as a consequence of): cholangits Examiner cendin Sequentially list conditions, if any, leading to immediate cause. In the trivial right, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ Mo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an performed 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No investigation iter death. I Director A o in by the fi 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours To the Funeral I completely filled Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Dev) Year) NOV 2 0 2007

30. Name

29b. Signature and title of certifier

n addres of person who comple

queline

Registrar's Signature

use of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State	of Marylan	id / Depa <i>Ce</i> a	artment of rtificate of	Health an Death	nd Mental Hy	giene 0	07	39257
	Physic	ian	1. Decedent's Name (First, Middle	,					2. Date of Do Month November	Day	Year	3. Time of Death 4:28 P M
	/Medi		Katie Senseni  4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location of D			007 ty of Death	1.20
	Examir	iei	41200 Bishop Road	, ,				hanicsvi			St. Ma	
1	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24	Hrs. 8. Date of Bi	rth ,	9. Birth	place (State or Foreign
ш	Director		182-30-0299	1 □ M 2 🖾 F	73	Yrs.	Months Days	Hours		er 5,1934	Cou	ntry) Sylvania
	P.		Usual Residence of Decedent		40- 00					, , ,		
	arylaı show dat	_	10a. State 10b. County		10c. Cit	y, Town or Lo						10d. Inside City Limits
	Ba-f	cto		Mary's				micsville	e			1 □Yes 2 ☑ No
	vith th	E E	10e. Street and Number				10f. Zip Code			10g. Citizen of	f What Cou	ntry?
	s 23a	Funeral Director	41200 Bishop Road	10.14 D-		0 10	N = 1 1 1	20659			JSA	1-12-
	ltem ner n	nu.	11. Marital Status	Armed F		.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	0-   14. Ha   Bla	ace - Americ ack, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	I If Yes, G	2 ☑ No live Dates:		1 □ Yes 2 ☑ No	Specify:		Spec	ify: Wh	ite
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	ed	15. Deceden	t's Education		16a. Dece	dent's Usual Occi	pation		16b. Kind of I	Business/In	dustry
215	Medi	plet	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of work don DO NOT use retir	ed) during most of	f working			•
212	d withingiene.	Completed	88	Conege	(1 401 01)	Hom	emaker			Owr	n Home	
b	be filed Ital Hygi Id other event, ti	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	e, Maiden Surna	ame)	
Maryland	should be Ind Mental Ind Mental Ind marked o	2	Aaron Brubacker						Rebecca	Sensenig		
Mar	and 2 sho alth and 1 27 Is ma er trauma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Stree	t and Number o	or Rural Route Numb	ber, City or Towi	n, State, Zip	Code)
	1 and Health em 27 ither tr		Irvin Brubacker G	ehman / Son	100h F		Bishop Ro		nanicsville,			
0	Pages 1 nent of F int: If Ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from			sition (Name of matory or other pl ennonite	, 110	Date ovember 30,	20c. Location	•	
Baltimore,	t. Pa ntmer ntant:		4 □ Donation 5 □ Other (S			etery			2007	Earttown	p,	Pennsylvania
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy orliquity or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	evru Par	dinei S	7	Mattingle P.O. Box	y-Gardine	er Funeral H onardtown, M	ome, P.A. D 20650		
\$			23a. Part1. Enter the disease, shock, or heart failure. Lat	complication that only one cause on	caused the deat	h. Do not ent	er the mode of dy	ing, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ a.	KES	Dirai	orest	arlu	20			9nset and Death
	/Medical Examiner		resulting in death)	Due to	s a consec	ence of:	711	Jan V	TE V	n 1		14:41
	LXUIIIIICI	<u>.</u>	Sequentially list conditions,	b. Due to	Con	W	VENE	au	1 auch	122		MAG
	ted 1sit	nju	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dag 10	Cars	ence on:	2111	VK.				40
	execu al-trai	Examiner	that initiated events resulting in death) Last	c	(ogas a conseq	uence of):	ALA	Way.				P
68760,	The law requires that the death certificate be executed tte has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	edical 8			Cosen	and	ANG	rest	)52_			45.
89	ificate g phy as the			u	0,00,00		1000	1				
Вох	death certific attending p	Physician/Me	IF FEMALE; 23b. Was decedent pregnant		utcome pf pregna			χ.		23d. D	ate of deliv	ery
œ.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🖪 No	4□Preg	birth 2 □ Feta nant at time of d	leath 3L	Ectopic pregnan Other (s <i>pecify)</i>	cy		N	lonth	Day Year
P.0	at the by th tache	hys	9 ☐ Unknown	9□ Unki	nown		_					
s,	w requires that the death been signed by the atte should be detached for	by F	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
Records,	equir en si ould I			2-1	A-		<i>/</i> }		_ 10	Yes 2 No	3 ☐ Prol	bably 4 ☐Unknown
ecc	has be be 2 sh	Completed	Justal	EX KE	nal 1	au	WVS		24a. Was		. Were auto	opsy findings available impletion of cause of
		E O		/ 1	( ,				perf	ormed?	death?	•
Vital	sician: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?						Death (Check only			
or/	ys dis	2	1 ☐ Yes 2 No		Inpatient 2		1 3 DOA		ng Home 5 🗗 Res	idence 6 □O	ther (Specia	fy)
	ding Ph h. After th funeral	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	9	e of Injury nth, Day Year)	28b. Time of Injury	We			how injury occu	ırred	
Sio	Attending r death. ector: After by the funer	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not he				]Yes 2 ☐ No				
Division	or At after c Direc in by	Certification:	4 ☐ Homicide determ	ined Zoe. Plac	e of injury - At no ding, etc. (Specify	ome, tarm, str y)	eet, factory, office	•	28f. Location ( City or To	(Street and Num wn, State)	nber or Run	al Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical	Examiner: On the I	basis of examina	wledge, deatl	n occurred at the vestigation, in my	time, date and p	place, and due to the occurred at the time	cause(s) and n	nanner as s	stated. o the cause(s)
	thin 2 thin 2 the comple	Medical	one) 29b. Signature and title of pertifie		nner stated.		29c Licen	se number		29d. Date sign	ed (Month	Day Yearl
_	F ≥ F ŏ			11600	borton	> M	ID	D/UI	19	11_	29 -	07
1	DK.		30. Name and address of person	who completed to	se of death (Item	23a) (Type	Print) Ton	DO T	Jarboe, M.	D v i -i	17	- 1
2	Z / )		24035 Three M	1.1			MD 2063		ournoe, H.	• •		
	Sta	ite	31. Date filed (Month, Day, Year)	. 82.1	gistrar's Signa							

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Joanne Florance Grimley November 25, 2007 12:15 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 26729 Yowaiski Mill Rd. St. Mary's **Mechanicsville** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 216-68-9842 Yrs 52 Director 17,1955 Vermont Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner ower by notified at 1 Yes 2 No Director Maryland | St. Mary's Mechanics ville 10e. Street and Number 10g. Citizen of What Country? 26729 Yowaiski Mill Road 23a 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? "natural", or Itama 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "na any injury or other traumatic event, Ita Mading 2006. Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Shah Associates 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Albert Legg Edna Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Grimley. III/ Spouse 26729 Yowaiski Mill Rd., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols 4 □ Donation 5 □ Other (Specify) 11/30/2007 Charlotte Hall, MD 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 MOUS/7 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Adendar cinama - Cholangiolarcinoma **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2€ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu investigation М 1 TYes 2 □No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50686 LOOS UDV ZU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. LHHARRA, 24035 Three Notch Road, Hourwood BU RDEEP 31. Date filed (Month, Day, Year) **B**istrar's Signature 32. P State 8 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 07-09144 2007 39259 Christian Hromada Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 11/26/07 Physician/ 1137 hrs November 25, 2007 Christian T. Hromada xaminer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days Country)Maryland March 19, 2007 Director 8 1 X M 2 F 219-77-9367 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County 1 Yes 2 X No 28a-f show Anne Arundel Hanover Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21076 55 Chesapeake Mobil Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married permit. Pages I and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene.
Important: If item 27 is marked other injury or other irres. 2 X No 1 Yes Specify: White Divorced If Yes, Give Year Yes 2 X No specify: 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/AN/A18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susan S. Hromada Be Unk (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 55 Chesapeake Mobil Court Hanover, MD 21076 Susan S. Hromada/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland National Cemetery 12/01/2007 Laurel, MD Donation 5 Other Specify: 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 f. Kusly 100 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and ysician failure. List only one cause on each line Death a Sudden Unexplained Death in Infancy **l**edical Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed AMENDED 23a,27,28a-f per ME g878 4/10/08 amh Physician/Medical X UNPENDED attending physician for use as the burial 23d, Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ور Unknown signed by the a 1 be detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown b 24b. Were autopsy findings available Completed 24a. Was an s been s prior to completion of cause of autopsy death? performed? has 1 🗸 Yes 2 No ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> Hospital: 1 Other: Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After Certification: 1 Yes 2 X No 1 Natural Pending Fnd 11/26/07 Fnd 11:15a Funeral Director: tely filled in by the 24 hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 55 Chesapeake Mobile Ct. 6 X Could not be 3 Suicide Janover MD determined (Specify) Other-Scene Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the F and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 27, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 32. Legistrar's Signature 31. Date filed (Month, Day, Year) State 4 2007 OCME Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** aenher Edna M. Hines 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔽 579-24-7641 82 Director 10/1/25 Wadesboro, N.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2€ No Director D.C. Washington 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 1737 Trinidad Ave., N.E. # 2 20002 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 | Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 Widowed 4 ☐ Divorced Black Baltimore, Maryland 21215-00 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levanda Gaddy Eva Redfern 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria A. Robinson/Daughter 710 59th Avenue, Capitol Heights, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Washington Nat'l. Cem. 11/24/07 Suitland, Maryland 22. Name and Address of Facility A Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee iano N. 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner telstak con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examine death certificate be executed physician and s the burial-transit neu mor Box 68760. Physician/Medical IF FEMALE: for use a yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9☐Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate l Division or Vital 1□ Yes 2☑No director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 1 Inpatient To the mosphers, within 24 hours after death. To the Funeral Director: After this of the funeral director. ည 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature an d title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar F120bith

31. Date filed (Month, Day, Year)

NOV 2 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Main

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		irtment of H			iene [	)7	39261
Н		(3)	Negistrar     Necedent's Name (First, Middle, Last	)				2. Date of Dea	th		3. Time of Death
	Physicia		Deborah E.	Jenrette				Month Novembe	r 16, 2	Year 007	1250 <sup>M</sup>
	/Medic Examin	m <sup>2</sup>	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	110101111111111111111111111111111111111	4c. County		
	5 .	•	Prince George's	Hospital		Chever	1v		Prin	ce Ge	eorge's
airi Ta	Funeral		Social Security Number     6. Se	x 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day			ace (State or Foreign
	Director		579-72-0470	⊐м 2⊠F 54_	Yrs.	monaro Dayo		July 18	, 1953	Washi	ington, DC
т	pu ,		Usual Residence of Decedent  10a, State 10b, County	10c City	, Town or Loc	cation				10	Od. Inside City Limits
	aryla shov	<u>_</u>	Maryland Prince			Pleasant					1 TyYes 2 □ No
	he M 8a-f otifie	Director		eorge 5	beat	10f. Zip Code			0g. Citizen of W	/hat Count	try?
	a or 2		10e. Street and Number								
	sath	eral	205 West Mill Ave	nue 12 Was Decedent Ever in U.	S. 13. V	20743	spanic Origin? (Sp			- America	an Indian,
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No	i	Vas Decedent of Hi f Yes, specify Cuba		Rićan, etc.)	Blac	k, White, e	etc. rican
213-0030	is filed within 72 hours after death with the Maryland Il Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notifiled at	by	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Dates:	1	I∐Yes 2½∏No	Specify:		Specify		erican
ş	2 hou atura cal E		15. Decedent's Ed	cation	16a. Deced	lent's Usual Occupa	ation	ina	16b. Kind of Bu		
2	in "n In "n Medi	ple	(Specify only highest grad	College (1-4or 5+)	life. [	DO NOT use retired	) -	lily .	Design		
7	d with giene gr tha the	Completed		2 years		Data Ope			Privat		
2	al Hy lothe vent	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surnam	e)	
<u>a</u>	Ment Ment arked arked attce	흔	William Tillmar	1	<del></del>			a Andrev			
Maryland	2 sho and l Is ma		19a. Informant's Name/Relationship (7		1	g Address (Street a			-		
Σ.	and and in 27		Nathan Jenrette -			West Mill					
e O	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Dispo emetery, crer	sition (Name of matory or other plac	e)	Date	20c. Location -	City or 10	wn, State
Ē	Pag ment ant: I		4 Donation 5 ☐ Other (Specify	) Ha		Mem. Park		27, 2007			
baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Si hature of Funeral Service Licen	The cool		2. Name and Address 4001 Benr					
À.			23a. Part1. Enter the disease, or comp shock, on heart failure. List only	lications that caused the death							Approximate Interval Between
	Physician	0.0	Immediate Cause (Final	Arterioscl							Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequ		neart Di	Locase				
	Examiner			Type II Di	abetes						
	200	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq							
	uted d ansit	Examiner	inat initiated events	<sub>c</sub> Peripheral	Arter	ial Disea	ase				
Š	an ar rial-tı	E	resulting in death) Last	Due to (or as a conseq	,					Ì	
28/60,	icate be executed physician and s the burial-transit	edical		d Hyperlipem	ia						
_		Med	IF FEMALE:							1	
X Q Q	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	ıldeath 3□	Ectopic pregnancy	1		1.7	te of delive inth	ery Day Year
	e deg	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath 5L	Other (specify)					
л Э	w requires that the deben signed by the should be detached	Ph/	Part II. Other significant conditions	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
<b>Records</b> ,	ires t signe	by	Tate II. Out of Significant Section 1					15(	res 2 □ No	3 ☐ Prob	pably 4 □Unknown
5	requ	Completed									findings available
စ္	e law	nple						24a. Was	sy		psy findings available mpletion of cause of
		S						1□ Yes	3√□ No	1 ☐ Yes	2□ No
VITal	hysician: The law his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		ot 201004 Oth	26. Place of Dea				- * *
	0 + 0	은	1 ☐ Yes 2 № No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatier 28b. Time o	IL 3 DOA	4 LI Nursing H	ome 5 Resid	dence 6 ∐Oth now injury occur		(y)
2	ing After une	ion:	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk? Yes 2 □ No	200. (2001)50 1	iow injury occur		
S	r Attending er death. rector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		ome farm sti		103 2 110	28f Location /5	Street and Numb	er or Rura	al Route Number,
DIVISION OF	or Ai ifter of Direction by	Certification:	4 Homicide determined	building, etc. (Specif	fy)	oot, ractory, omeo		City or Tov	vn, State)		
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	owledge, deat	th occurred at the ti	me, date and place	, and due to the	cause(s) and m	anner as s	stated.
	24 h	edical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	ation and/or in	rvestigation, in my	opinion, death occu	irred at the time,	date and place,	and due to	o the cause(s)
	To th Within To th comp	Me	29b. Signature and vile of certified			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
)	5		1	w_		NZ	5947		11/19	(0)	
1	1-		30. Name and address of person who		n 23a) (Type,	Print)	1			-	
_	4//		Arramis. Mela	y wo 10274 LO	WE ALL	muny #2	- min	ellelle	, and 20	721	
6		ate	31. Date filed (Month, Day, Year) NOV 2 1 2007	32. Registrar's Signa	ature	1				)	
	Regist	rar	MAA S I SOOL	Deven A.	E Parket						

MD

Items 23a or 28a-f ehow permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a any njury or other traumatic event, the Maxingal Exampler must once. Baltimore, Maryland 21215-0036

**Funeral** 

Director

**Physician** /Medical

Examiner

Division of Vital Records, P.O. Box 68760

FREDE

ruller	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent of If Yes, specify C	Hispanic Origin? (Speci ban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit			
	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>X</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐X	o Specify:		Specify: W	hite		
פופח	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's Usual Occ (Give kind of work do	upation e during most of working red)	16b.	Kind of Business	Industry		
completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker	red)		Own Hom	e		
נ	17. Father's Name (First, Middle, Last)	·		18. Mother's Name (	First, Middle, Maide				
ם כ	Joseph W. Taylor			Virgin	nia Harmon	า			
	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing Address (Stre	et and Number or Rural I	Route Number, City	or Town, State, 2	Zip Code)		
	Leo Harold Kilgor		11303 Assato	eague Rd., B					
	20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremation 3 🗆		ace of Disposition (Name of metery, crematory or other p		2001	Location - City or			
	4 □ Donation 5 □ Other (Specify	Sun	set Memorial	Park 11/24	1/2007 Be	erlin, M	D		
	21. Signatore of Fund al Service Licen	see	22. Name and Add	ress of Facility The am St., Ber	Burbage		Home		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death.					Approximate Interval Between		
	Immediate Cause (Final disease or condition	Aspira	tree Pa	enmoura	i.		Onset and Death		
	resulting in death)	Due to (oras a gonseque	ence of):	10 /	•		70.0		
_	Sequentially list conditions,	b. Due to for as a conseque	uer 9 N	enen tra	a		Las.		
	f any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury								
4	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):				-		
8		d							
5	15.55.44.5								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1□Live birth 2□Fetal d	death 3 Ectopic pregnar			23d. Date of del Month	ivery Day Year		
2	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	ath 5 ☐ Other (specify)				,		
	Part II. Other significant conditions co	ontributing to death but not result	ting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to	the cause of death?		
2					1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Dunknown		
					24a. Was an	24b. Were au	utopsy findings available completion of cause of		
5					autopsy performed?	death?	completion of cause of 2□ No		
3	25. Was case referred to medical			26. Place of Death	Check only one	T Tes	- L INO		
נ כ	examiner?	Hospital: 1 denpatient 2 □ El	R/Outpatient 3 DOA	ther: 4 Nursing Home		6 ☐Other (Spe	cifv)		
1	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In	ury at 28 ork?	d. Describe how inj	ury occurred			
	2 ☐ Accident investigation			☐ Yes 2 ☐ No					
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, offic	e 28	f. Location (Street a City or Town, Sta	and Number or Ru te)	ural Route Number,		
300	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysicien: To the best of my knowl liner: On the basis of examinatio and manner stated.	ledge, death occurred at the on and/or investigation, in m	time, date and place, an opinion, death occurred	d due to the cause( I at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)		
	29b. Signature and title of certifier	/		nse number		ate signed (Mont			
	M/ G Mu	Mus	> D6	28269	11	1226	76		
	30. Name and address of person who of Nicholace Pore	completed cause of death (Item 2	23a) (Type, Print) (>09 Ce	stal Hylu	r, Few	ect for	ed De 1994		
	24 D to 12 d 04 of 0 - Word	22 2 1 2 1 2			7				

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 26, 2007 2:30 a.m. Arthur Kispert November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Director 470-32-3827 76 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes XX No Directo St. Mary's Maryland St. Inigoes 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20684 United States 47866 Waterview Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ If Yes, Give Year or Dates: 2□No 1 ☐ Never Married 2K Married Specify: White 1 ☐ Yes 2 🛛 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commissioned Officer United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Hildebrandt ပ Ervin Kispert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle M. Kispert / Wife 47866 Waterview Drive, St. Inigoes, Maryland 20684 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episcopal Cem 11-29-2007 St. Mary's City, MD 21. Signature Funeral Sorvice Licensee

Edward N. Brinsfield Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause \_\_ each line. Immediate Cause (Final Physician Yator disease or condition resulting in death) /Medical Due to (or a /a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner neumon Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certific te has autopsy 1□ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

State

2

(Check only one)

29b. Signature and

31. Date filed (Month

30. Name and

DHMH 17 Rev 1/2001

Registrar

Guess of person who completed cause of death (Item 23a) (Type, Print)

jistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

07-09035	
Anthony Langley	

DHITH IT NO 10001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthony Langley		State of Maryland / De	epartment of Ce <i>rtificate of</i>		d Mental F		a. No. 2007	39261
Physician	/	. Decedent's Name (First, Middle,Last)				2. Date of Death Month November		3. Time of Death 2108 hrs
/ledical Examine		Anthony Lang  a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		22, 2007 4c. County of Death	21001113
		2809 Iverson Street		Temple Hill			Prince George's	S
Funeral Director	5	5. Social Security Number 6. Sex 7. Age (In 1238–23–2458 1 X M 2 F 40	yrs. last birthday) Yrs.	If Under 1 Year Months Day			, 1967 (MM/DD/YYYY) 9. Birth Foreign Cour	place (State or North <sup>Ntry</sup> Carolina
ź			City, Town or Location	ion				10d. Inside City Limits
re Pie	_ M	aryland Prince George	Temple Hil	11s				1 Yes 2 X No
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show any end to the Medical Examiner, must be notified at once.	ווס	10e. Street and Number 2809 Iverson St.		10f. Zip Code 20748		10	g. Citizen of What Count USA	ry?
death with or items 23 must be no		1. Marital Status 1. X Never Married 2 Married Armed Forces? 1. Yes 2. X	No If Yo	es, specify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ White, etc. Specify: Blac	
s after rral", o	⋧┞	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete		Yes 2 X No		of work done	Specify: 16b. Kind of Business/In	
2 hour "natu	ا <u>يو</u>	Elementary/Secondary (0-12) College (1-4 or 5+)		nost of working life				·
-0036 I within 72 hours aft gene. gene. Medical Examine	Completed	12th	Maint	enance			Dreyers Id	ce Cream
21215-0036 Buld be filed within 72 hours after Mental Hygiene. marked other than "natural", c		17. Father's Name (First, Middle, Last) Heyward Bowers			18.Mother's Nar Delois	me (First, Middle, M Lai	Maiden Surname) ng1ey	
	ᆈᆫ	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing	g Address (Stre			ber, City or Town, State,	Zip Code)
MD d 2 sho Ith and In 27 is	L	Antionette Bowers/Sister	2013 20b. Place of Dispos			ve. N.W.	Apt. 102 Was	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic cr.		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Dogetion 5 Other Specify:	crematory or oth Kalas Cr	her place) ematory	12/	2/2007	Edgewater,	Maryland
Salti ermit. Separtir mports njury o		21. Signiture of Funeral Service Licensee	22. N 61	Name and Addres	ss of Facility e	orge . . Oxon H	alas unera ill, Md. 207	ome 745
Physician		23a. Part I I nter the disease, it complications hat caused the						Approximate Interval
/Medical.		failund. List only one cause on each line.  Immediate Cause (Final disease a. Hanging						Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a conseque	nce of):					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ince of):					
to, e be executed sician and burial - transit	EX	(Disease or injury that initiated events resulting in death) Last  Due to (or as a conseque d.	ince of):					
e be exe	edical	X AMENDED X #ZOB, perFD, 2	23a,27,28a-f	, perME,g	874, 12/13	3/07 TT	Lood Date of deliver	
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	<b>&gt;</b>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Fe	etal death 3	Ectopic pre	gnancy	23d. Date of delivery  Month	yay Year
Bo he deat the at hed for	y y	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but	t not reculting in the	underlying cause	niven in Part I	23e. Did to	obacco use contribute to	the cause of death?
, P.O. res that the signed by be detach	৯	Part it. Other significant conditions — contributing to death but	t not resulting in the	underlying cause	s given in i dit i.	-		ably 4 Unknown
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  The law requires that the after this certificate has been signed by all Director: After this certificate has been signed by the funeral director, page 2 should be deather in the funeral director, page 2 should be deather than the funeral director, page 2 should be deather than the funeral director, page 2 should be deather than the funeral directory and th	Completed					24a. Was autop		topsy findings available ompletion of cause of
ecol he law ite has	삞		-	<u></u>	-		rmed? death?	
al R	ğ B	25. Was case referred to medical		26.Pla	ce of Death (Che			
Division of Vital Records, pital or Attending Physician: The law requirents after death.  reral Director: After this certificate has been stiffed in by the funeral director, page 2 should	일.	examiner?  1 V Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien 28b. Time of		Other <sub>4</sub> Nu		Residence 6  Other	: Scene
on of ding I th. : Afte		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)		\	Yes 2 XNo		hanged self	
r Atter ter dear irector in by th	licat	2 Accident Investigation Fnd 11/22/	2007 Fnd 8:5 - At home, farm, stre		e building, etc.		Street and Number or Ru	ral Route Number, City
Div pital o	Certification:	4 Homicide determined (Specify) Hous				2809 Iver	son Rd Temple	
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn one)  2 Medical Examiner: On the basis of examination and manner stated.	iowledge, death occu ation and/or investiga	ation, in my opini	on, death occurre	and due to the caused at the time, date	and place, and due to th	e cause(s)
->-0	ž	29b. Signature and title of certifier			nse number C.M.E.		29d. Date signed (Mo. November 25, 20	•
		tandley Justrall, MI)	h /ltem 22a)		J.1VI.L.		110101111101 20, 20	
	C 100	30. Name and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical		11 Penn Stre	et, Baltimore	e, MD 21201		
Sta		31. Date filed (Month, Day, Year) 32. Registrar's S		soli)				
Registr	cli	UFL U I COUI PAGE						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Mildred Marie Leeland 23, 10:50 p November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40880 Leeland Road Mechanicsville St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 ☐ M 2 💢 F Director 578-30-2157 82 10/15/1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2X No Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20659 40880 Leeland Road <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", or Specify þ Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph G. Smith ဥ Caroline Schultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: if Item 27 is any injury or other traconce. Clinton H. Leeland/Husband 40880 Leeland Road, Mechanicsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 11/27/2007 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL **Physician** /Medical Due to (or as a consequence of): Examiner SCHEMIC CARDIO MYO PATHY Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed CRONAKY attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been ; , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2D No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🗌 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier .11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA DB096 11-26-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJBINDER ASSOCIATES , HOLLYWORD 0 SMAH GILL 31. Date filed (Month, Day, Year) Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Michael Mitchell Thomas November 17, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** eninsula K (NIC8M/ 20 Center alisbure RG lonal If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F Director 5/25/1954 215-62-0397 53 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 11398 Beechwood St., Apt. F USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon F. Castro/advocate 30260 Mt. Vernon Rd., Princess Anne, MD 21853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Salisbury Crematory 11/20/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 2. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Math 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Meumonia **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner as the burial-transit Douces abuse To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ ancen 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 WNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 XNo 1 npatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1 dr

State Registrar 31. Date filed (Month, Day, Year)
NOV 2 1 200?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2 137 Elm St Pro 32 Pegistrar's Signature

07-08976	Please Type or Print in Black Indelible In		ible.
Sylvia Cylinda Mar	shall State of Maryland / Department of 1- For State Certificate of	Doath	No. 2007-3926
Physician	Registrar	2. Date of Death	3. Time of Death
Medical Examine		Month November 2	
Y and the second	4a. Facility Name (if not institution, give street and number) 6814 Walker Mill Road, Apt. 102	4b. City, Town, or Location of Death Capitol Heights	4c. County of Death Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		(MM/DD/YYYY) 9. Birthplace (State or Foreign WASHINGTON
Director	578-58-6210 1 M 2 F 62 Yrs  Usual Residence of Decedent	JOLY 17	DC
w any	10a. State 10b. County 10c. City, Town or Locat		10d. Inside City Limits  1 X Yes 2 No
yland f sho f sho	MD PRINCE GEORGE'S CAPITOL		g. Citizen of What Country?
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  In marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Completed by Finneral Director		20743	USA
or death with , or items 23	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Married Porces?	as Decedent of Hispanic Origin? (Specify Yes or No- 'es, specify Cuban, Mexican, Puerto Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
ler dez		Yes 2 X No specify:	Specify: BLACK
ours aft atural" xamine	or Dates:		16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. bygiene han "natu he Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) COMPU	TER SPECALIST	PRIVATE
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, M.	aiden Surname)
215 be file mtal Hy rked o rked o		MILLIE HARPE	ER .
21 nould I not Mer is mar ritic eva	2 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailin	g Address (Street and Number or Rural Route Numb	·
MD and 2 sho salth and 2 sho san 27 is raumati		HAYES STREET LANHAM, MAR	20c. Location - City or Town, State
altimore, rmit. Pages I at ppartment of He ipportant: If ite jury or other to	1 XBurial 2 Cremation 3 Removal from State crematory or ot	ther place)	·
ltimit. Pa	4 Donation 5 Other Specify HARMONY 21. Strature of Funeral Service Liver ee		LANDOVER, MARYLAND KINS FUNERAL HOME
Ba Perm Depa Impu	110	474 LANDOVER ROAD LANDOV	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter t failure. List only one cause on each line.	he mode of dying, such as cardiac or respiratory arre-	st, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease	ase	Death
	b		
100	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): eause. Enter Underlying Cause		
ted nisit	(Disease or injury that initiated events regulting in death) Last Due to (or as a consequence of):		
execui	O. LINDENDED AMENDED		
68760, certificate be noting physic as the burian / Moor	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
c 68760, I certificate be eending physicia	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 0	etal death 3 Ectopic pregnancy  ther (Specify)	Month Day Year
D. Box the death c by the attent by the atte	1 Yes 2 No 9 Unknown g Unknown	their (Specify)	
P.O.	Part II. Other significant conditions contributing to death but not resulting in the		bacco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown
duires the en signer alid be defined.		[ 24a. Was a	
Vital Records, hysician: The law requires this certificate has been significated, page 2 should be formal of the Completed.		autops perfori	sy prior to completion of cause of
Recipients The		1 Yes 2	2 No 1 Yes 2 No
Vital ysician ysician director		26.Place of Death (Check only one)	Residence 6 🗸 Other: Scene
n of Vi ing Physi After this uneral dir	27 Manner of Death 28a Date of Injury 28h Time of	Injury 28c. Injury at Work? 28d. Describe h	ow injury occurred
ion of tending Pheath to: After the funeral	1 Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	
Division o Hospital or Attending 24 hours after death frament Director: After death etch filled in by the fune	3 Suicide 6 Could not be determined	eet, factory, office building, etc. 28f. Location (S or Town, St	Street and Number or Rural Route Number, City tate)
lospita I hours uneral		urred at the time, date and place, and due to the causi	e(s) and manner as stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burification: To Re Completed by Physician/Mod	one) 2 Medical Examiner: On the basis of examination and/or investigation		
E S E S	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Pamek & Justhall, Mi)	O.C.M.E.	November 21, 2007
H	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 11	11 Penn Street, Baltimore, MD 21201	
Stat	e 31. Date filed (Month Day Year) 32. Reinstrar's Signature	· · · ·	
Registra	DEC 2 6 2007 June 15	OCA	ME .

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 2007 РМ Wilma Gail Monaco 3:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🖸 F 400-30-2318 Director July 30, 1925 Kentucky Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Director Maryland Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 940 Bay Forest Court Apt. 115 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If Item 27 Is marked other than "natural"; or ite 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No Specify. þ Specify: White 3 Nidowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dan Griffith Ruth Prine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trau Phyllis J. Diamond / Daughter 801 South Ocean Drive Apt. 1001 Hollywood, F1 33019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-16-07 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory Edgewater, Maryland 21. Signature Ineral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a Deft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Offset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Mont egistrar's Signature State

Registrar

2 0 2007

NOV

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Certificate of Death

**Physician** /Medical Examiner

**Funeral** 

Director

death with the Maryland or items 23a or 28a-f shiminer must be notified Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter Hygiene.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-tran physician the death certificate be the SS use Por To the Hospital or Attending Physician: 24 hours a within 2

Division or Vital Records. P.O. Box 68760.

1. Decedent's Name (First, Middle, Last) Month NOV. 29, 2007 10:18A M UNA LEE MASSEY MCLEER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7769 COUNTRY CLUB LANE CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Months Days 1 □ M 🛣 F DEC. 3, 1924 CT82 049-16-3821 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7769 COUNTRY CLUB LANE 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify WHITE 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** 12 5+ SPEECH PATHOLOGIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNA LEE TUCKER AUGUSTINE HERMAN MASSEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7769 COUNTRY CLUB LANE, CHESTERTOWN, MD 21620 UNA LEE MCLEER PENNINGER/DAU. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition NOVEMBER 30 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the discase, a completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death tand Dea... Immediate Cause (Final Cholanjo arinoma disease or condition resulting in death) Due to (or as a conjequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ hypothyroid 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dicoppost20 autopu performed: 25 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Nursing Home 5 Residence 6 ☐ Other (Specify) 20 No ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51735 s of person who completed cause of death (Item 23a) (Type, Print) MD town. 6602 Church Hill Rd ste 200 Frederick State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 Day **Physician** Edith Marchesiello 21 2007 12:29 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Living of Ocean Times Pines MD Worcester Ocean 8. Date of Birth (Month, Day, Y 7/21/191 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕅 F Hours 102-05-6945 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " any injury or other traumatic exercitions." 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Ocean Pines Worcester 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 3 B Mallard Dr. East 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adigio John Pasquali Blanche Piazza 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Marchesiello /son B Mallard Dr. East, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Charles Cemetery 11/29/2007 | Long Island, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Fan yea D disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 XNo been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performe or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

BAY State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 2 6

Lorren

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.P.

320 Registrar's Signature

DOMMOTER

2007

DHMH 17 Rev 1/2001

10514 Rucetrak Rd unit C

29c. License number

29d. Date signed (Month, Day, Year)

Berlin

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CHARLES ROBERT MUMFORD Vovember 20 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Mounico REGIONAL 54415641 Peninsula Modical 8. Date of Birth JULY 13, 1958 If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☑ M 2 ☐ F Davs Hours Min. MARYLAND 49 214-70-6175 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Iral", or items 23a or 28a-f shov Examiner must be notifled at DELAWARE SUSSEX 1 ☐ Yes 2 X No MILLSBORO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21548 CAREYS CAMP ROAD 19966 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 GYes 2 No 1977− If Yes, Give Year or Dates: 2007 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No BLACK à 3 Widowed 4 Divorced "natural" 2007 Completed other traumatic event, the Medic at 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LEAD FOREMAN MAINTANANCE marked other 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT CHARLES PITTS RACHEL MUMFORD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S ANDREA M. HUDSON MUMFORD / WIFE 21548 CAREYS CAMP ROAD, MILLSBORO, DE 19966 Item 27 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 'Department of Important: If Ite any injury or of 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State DE VETERANS CEMETERY MILLSBORO, DELAWARE 11/27/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility WATSON FUNERAL HOME 211 WASHINGTON ST, MILLSBORO, DE 19966 21. Signature of Funeral Service Licensee MO0268 lore 23a. Part1. Ent: the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Ö signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 MUnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy page this certificate Vital 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No 2 ER/Outpatient 3□ DOA ဥ 1 Inpatient Division or 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Natural within 24 hours after com... To the Funeral Director: Aft М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title or certifie

DHMH 17 Rev 1/2001

State

Registrar

BA 10+1

30. Name and address of person

Simona Eng. 1002 31. Date filed (Month, Day, Year)

NOV 2 6

100E Carrell

2007

5%.

32 Registrar's Signature

of death (Item 23a) (Type, Print)

SAlisbury, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

awon ivilles	1	For State Registra Ameno# s17.&19.PerFF	waryiano / Depai <del>-ipg~1</del> 2–3–07 <i>d</i> €e <i>ri</i>			rivientarriy	. Reg.	No. 200	7 39272
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2012 3 0702				2. Date of Death		3. Time of Death
ledical Examin		Dawon Mauric					Month D November 1		1724 hrs
	П	4a. Facility Name (if not institution, give street 12701 Thrush Place	et and number)	1	City, Town, or L Jpper Marlb	ocation of Death		4c. County of Death Prince George	
Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	f Under 1 Year	If Under 24Hrs.	8. Date of Birth(	MM/DD/YYYY) 9. Bir	thplace (State or
Director		218-29-2433 <sub>1</sub> X <sub>M</sub>	2 F 20	Yrs.	Months Days	Hours Min.	Feb. 24	, 1987 Co	m Washington, DC DC
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
	١	Maryland Prince Ge	orge's Up	per Marl	boro				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		11	0f. Zip Code		10g	. Citizen of What Cou	ntry?
h the h		12701 Thrush Place			20772			United Sta	
ath wit tems 2 st be n	Funeral	11. Marital Status  1 Never Married 2 Married	. Was Decedent Ever in U.s Armed Forces?	S. 13. Was D If Yes,	ecedent of Hisp specify Cuban,	panic Origin? ( Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc. Af 1	rican Indian, Black,
fter des		3 Widowed 4 Divorced If Ye	Yes 2 No	1 Y	es 2 X No	specify:		Specify: Am	erican
lours a	eted by	15. Decedent's Education (Specify only hi				on (Give kind of w DO NOT use retir		6b. Kind of Business	/Industry
36 in 72 t han "r	plet	Elementary/Secondary (0-12)	College (1-4 or 5+)  1 year		udent			Private	
5-0036 fled within 77 Hygiene. J other than	Compl	17. Father's Name (First, Middle, Last)	1 year			18.Mother's Name	(First, Middle, Ma		
1218 be file ental H erked	Be	Keith M. Myles					y Wilson		
MD 21 nd 2 should ulth and Me m 27 is ma aumatic ev	욘	19a Informant's Name/Relationship (Type, Keith Maurice MTL - <del>Keith Myles</del> - Fath	es (		,			er, City or Town, State ${ m int}$ , ${ m MD}$ 20	
e, M and 2 Jealth Item 2 traun	ŀ	20a. Method of Disposition	20b. F	Place of Dispositio	n (Name of cen			20c. Location - City o	
more set of E		1 Burial 2 Cremation 3 F  4 Donation 5 Other Specify:	Tellioval Irolli State	rematory or other		Park Nov	21,_200	)7 Landov	er, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ı	2. Signature of Funeral Service Nicensee	A M	22. Nam	ne and Address	of Facility Ste	wart Fur	neral Home	, Inc.
		23a Part I. Enter the disease, or complicat	OLA ULA					nington, D	C 20019 Approximate Interval
Physician /Medical		failure. List only one cause on each li	ne. nshot Wound to Hea				, , , , , , , , , , , , , , , , , , , ,		Between Onset and Death
caminer			to (or as a consequence of						1
	<u></u>	Sequentially list conditions, if any, leading to immediate b.	to (or as a consequence of	f)·					
	Examiner	Cause Enter Underlying Couse (Disease or injury that initiated					<u> </u>		
ansit		events resulting in death) Last Due d.	to (or as a consequence of	t):					
ivision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial - transit	cian/Medical		MENDED		-				
760 ficate b g physi	We.	IF FEMALE: 23b. Was decedent pregnant in the	3c. If yes, outcome of preg		death 3 [	Ectopic pregna	incv	23d. Date of delive Month	ry Day Year
× 68 h certil	iciar	past 12 months?	Pregnant at time of de	- H	(Specify)			l monar	,
BO) he death y the att	Physi	1 Yes 2 No 9 Unknown g  Part II. Other significant conditions cor	Unknown	esulting in the ung	tertying cause o	iven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
i, P.O. B ires that the d signed by the	ğ	Tare in Other Significant Conditions	iniboting to death but not n	occitaing an area cris	,o,g 22200 g	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 Yes	2 No 3 Pro	obably 4 Unknown
ords, w require s been si should b	Completed						24a. Was ar autops		autopsy findings available completion of cause of
Reco The law icate has	dwo						perform 1 <b>V</b> Yes 2	ned? death?	
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?				of Death (Check			
1 of Vital I	P	examiner? 1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpatient 3		Other Nursir		Residence 6 Oth	er: Scene
on of nding Pl th.		1 Natural 5 Pending	FOUND: Day, Year)	FOUND:	, I	Yes 2 ✔ No	Subject shot	ow injury occurred	
Division all or Attendi rs after death. all Director: ded in by the fu	ficat	2 Accident Investigation 3 Suicide 6 Could not be	Nov 14, 2007 28e. Place of Injury - At h	1715 hrs ome, farm, street,	factory, office b	ouilding, etc.			Rural Route Number, City
Div pital o ours aff eral D	Certification:	4 V Homicide determined	(Specify) Single Fan		···		<u> </u>	Place, Upper Marik	
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:		29a. Certifier (Check only one)  2  Medical Examiner: On	To the best of my knowled the basis of examination a	ge, death occurre	d at the time, da n, in my opinion	ate and place, and n, death occurred	I due to the cause at the time, date a	e(s) and manner as stand and place, and due to	ated. the cause(s)
To t with To t	Medical	29b. Signature and title of certifier	d manner stated.	-	29c. Licens			29d. Date signed (M	
5		Carol H	allai	~	O.C.	M.E.		November 15, 2	2007
00		30. Name and address of person who com			root Dolti	oro MD 0400			
TEX .		Carol Allan, MD Assistant 31. Date filed (Month, Day, Year)		111 Penn St	reet, Baitim	ore, IND 2120	/ 1		
St Regist			A. Registral S digital	Sperke					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 11/99/07 Charles E. Mason -35 A M /Medical 4a Facility Name (If not institution, give street and number)
St. Thomas Moore Nursing, Rehab
and Dialysis 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince Georges If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Days 577-44-4608 73 Director 7/18/34 Wash., DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10d, Inside City Limits 10h. County MD Prince Georges Bowie 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be or 1308 Kings Heather Drive 20721 Usa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
12th Diploma College (1-4or 5+) Welder Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcelus Butler 2 Ida Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Kings Heather Drive, Susie Mason/Wife Bowie, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Wash., National 11/16/07 Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Reese Professional Funeral Service 21. Signature of Funeral Service Licensee 3605 14th St., NW, Wash., DC 20010 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death ser r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Immediate Cause (Final ANTERIOSCIENOTE COMBIOVASCULOR **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? Month Day 5 Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrillanon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Stage renal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 2 🗷 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death.

Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Disenson, Rd Hyatts ileMB20781 E KIS 4203 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nall 36 M Mae 12: /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Consideration Land over George 3 ane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Har 2 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 417-24-7688 1□ M 2 F Birmingham, Al. Director 85 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10h. Count 28a-f shov Examiner must be notifled at Yes 2 □ No andover Directo 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 1 any injury or other traumatic event, the Medical Examiner must be n 15A by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?/
1 ☐ Yes 2 D No If Yes, Give 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 □ Yes 2 □ X 0 Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be reen မ 19a. Informant's Name/Relationship (Type. Print) Doughtor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 consideration Lane Landover Hd 20785 phelia 20a. Method of Disposition 1 Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 3 □Removal from State NOV 29 200 Cheltenham 4 Donation 5 DOther (Specify Maryland Veterans 22. Name and Address of Facility Pope 21. Signature of Funeral Service Lie Home 20747 5538 Mari boro 7 Oras Forestville 23a. Part l. Enter the diseale, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learning to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown VASCULAR DISEASE CEREBRAL Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an performed? Yes 2⊠No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 🗌 Yes 2 🗆 No death. neral Director: / 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direc 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier raid NOVEMBER D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8724 Jericho City Drive, Landover MD. 20787 Martin Weltz, MD.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 1 2007

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	iryland /		irtment of F		мептат ну	giene Rag. No.	2007	39275	
	Physicia	an	1. Decedent's Name (First, Middle, La	•					2. Date of De	Day	Year	3. Time of Death	
	/Medic	_	Duane Harold Po						11	21	2007	10:56 A <sup>M</sup>	
	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, o		th		County of Deat		
	Funeral	-	Atlantic General 5. Social Security Number 6.3	Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth	Vorcesto	hplace (State or Foreign	
	Funeral Director		167-22-1537	IOXM 2□F 79	9	Yrs.	Months Days	Hours Min	4/26/	1928	Co	PA	
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, T							10d. Inside City Limits	
	anyta • hov	5	MD Worcest	an	0cea							1 ☐ Yes 2XXNo	
	28e-f	Director	10e. Street and Number	-1	ocea	11 611	10f. Zip Code			10a. Citi	zen of What Co	ountry?	
	3a or		12720 Old Bridge	Rd.			21842				USA		
	death me 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Vas Decedent of H		Specify Yes or No	o-	14. Race - Ame Black, Whit		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f ehow emportant: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f ehow empt futury or other traumatic event, Ite Medical Examinar must be notified at 9DCs.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🗷 Widowed 4 ☐ Divorced	1 Yes 2 XN If Yes, Give Year or Dates:	lo	1		Specify:	no moan, etc.,		Consider	nite	
ŏ	72 hou	ted	15. Decedent's E (Specify only highest gi		1	6a. Deced	lent's Usual Occup	ation	odkina	16b. Ki	nd of Business	Industry	
2	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT use retire	d) -	nung				
2	tygier her th	S	12 17. Father's Name (First, Middle, Las	1		(-	iroup Lea		ıme (First, Middle		estingho	ouse	
anc	ntal Hed of	Be	Carl Popp	,					na Hammon		Jumamer		
2	should nd Me mark matic	ြ	19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street				r Town, State, a	Zip Code)	
Z	alth ar 27 is r trau		Colleen Dinterma	n / daughte	er :	13 Rc	binhood	Trail, B	erlin, M	4D 21	811		
ore,	of Head		20a. Method of Disposition	TD Chair	20b. Place	of Dispo	sition (Name of natory or other place		Date		cation - City or	Town, State	
Ē	Page ment ant: ff ury or		1 ☐ Burial 2 📉 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special		Cape	Henl	open Cre	m.   11/	21/2007	Fra	nkford,	, DE	
Baltimore, Maryland 21215-0036	Departi Departi Import eny Inj pnce.		21. Signature of Funeral Service Lice	1 See			Name and Addre					Home	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
	Physician		Immediate Cause (Final disease or condition	a Chronic (		blie	ulman essu	Dirmo	0			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):	4	D13 CBC 1					
	Examiner	_	Sequentially list conditions,	b. Due to (or as a	F. C. W. F. Commission	es off							
	nsit	nIne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 00)	a comocquer	00 01).							
Ć	ficete be executed physicien and ts the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a	a consequen	ce of):							
68760,	ite be iysicie ne bur	edical		d						,			
_			IF FEMALE:							1			
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 ☐ Fetal de	ath 3	Ectopic pregnancy	/			23d. Date of de Month	livery Day Year	
P.0.	w requires thet the death certis been signed by the attending should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of deatr	1 5L	Other (specify) _						
٣.	thet i		Part II. Other significant conditions	contributing to death bu	ut not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?	
rds	quires nn sign uld be	ed by	Congestive H	eart failu	re				1)🛮	Yes 2	□No 3□P	robably 4 🗆 Unknown	
00	aw re as bee 2 sho	Completed	V						24a. Was			utopsy findings available completion of cause of	
Ĕ	The ate has page	E O								ormed? 2 X No	death?	2 No	
ita	cian: artific actor,	Be (	25. Was case referred to medical examiner?	l Hanning I			104		eath (Check only	one)			
ð	Physical this call direction	7	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER	Outpatier b. Time of		4 Unursing	Home 5 ☐ Res			cify)	
ОПО	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wo	k? Yes 2 □No	200. 5000150	now anjui	y cocarrou		
Division of Vital Records,	Attending Physicien: The law requires thet the death cent or death.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use it.	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Inju		, farm, str	eet, factory, office		28f. Location City or To			ural Route Number,	
ā	s efte et Din ed in l	Cert	4 - Homicide	building, etc	с. (Specity)				City of 10	wii, Siale	·/		
	To the Hospitel or Attending Physicien: The law within 24 hours effer death.  To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	Medical		nysician: To the best of miner: On the basis of and manner sta	examination								
	To the within To the	Me	29b. Signature and title of certifier	_			29c. Licens				te signed (Moni	th, Day, Year)	
)				·D				64120			21/07		
¥	3A10		30. Name and address of person who Zees han, Atif A	completed cause of do GH 9733 32. Registra	eath (Item 23 Healf)	Ba) (Type,	Print) drive	Berlin	MD	218	?//		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	/	1.11.						
	Registr		NOV 2 6	2007	va L	The party	Care.						

11/1948- 1/21/2007

poply DuALE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Grace Ridgell Pratt November 29, 2007 9:20 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 50285 Scotland Beach Road Scotland St. Mary's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛚 F 212-<u>32-5461</u> Director 11/28/1934 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Maryland St. Mary's Scotland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50285 Scotland Beach Road 20687 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Postal Clerk</u> U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Cecilia King <u>Joseph Austin Ridgell</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin L. Pratt, Jr./Son 8180 Linderman Road, Peyton, CO 80831 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Softice License Brinsfield-Echols Cre 12/03/2007 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastah bladde /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? Yes 2000No certificate ! 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: To the Hosp...
within 24 hours after us...
To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29c. License number 29b. Signatur 29d. Date signed (Month, Day, Year) D62288 1-30-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nikhil Uppal, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636 Date filed (Month, Day, Ye 32. Registrar's State Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State	of Marylar	•	artment of I		and Mer	ntal Hygi	ene		
			State Registrar			Cei	tificate of	Death			g. No. 2	107	39277
В	Physici	an	Decedent's Name (First, Middle	e, Last)						Date of Death Month	Day	Year	3. Time of Death
7	/Medic		Talmadge C.  4a. Facility Name (If not institution	Page	numborl		4b. City, Town, o	or Location of		11	18 2 4c. County	007_	12:15 P <sup>™</sup>
	Examin	er									Montg		7
	Funeral		Fox Chase NUrs 5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	Silver If Under 1 Year	1f Under 2	4 Hrs. 8	Date of Birth		9. Birthr	place (State or Foreign
	Director		579-50-0593	1 <b>∏x</b> M 2 ☐ F	69	Yrs.	Months Days	Hours		(Month, Day, 7- 01		Virg	inia
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ity, Town or Lo	cation					1	10d. inside City Limits
	faryla sho	ō	Tob. Godiny			.,,							1X Yes 2 No
	the N 28a-1	Director	10e. Street and Number		Was	shingto	n 10f. Zip Code			10	g. Citizen of	What Cour	ntrv?
	3a or		1229 G Street	S.E. #3	12		20003				USA		
	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was D	ecedent Ever in U Forces?	J.S. 13.	Was Decedent of It		gin? (Specify	Yes or No-	14. Rad	ce - Americ	
9	after or Ite		1 Never Married 2 Mar	ned 1 □ Ye	s 2 🔀 No		1 □ Yes 2⊠ No	Specify:	, rueno nica	an, etc.)		ck, White, fy: B1ac	
21215-0036	nours ural",	d by	3 Widowed 4 Divorced	Year o	r Dates:								ety.
5	"nat	Completed	(Specify only highe			(Give	dent's Usual Occu <sub>l</sub> kind of work done DO NOT use retire	during most	of working		l6b. Kind of B	iusiness/in	dustry
12	withi iene. r than the M	m o	Elementary/Secondary (0-12) 6th.	Colleg	e (1-4or 5+)		ruction			D	ent. o	f Sar	nitation
ğ	e filed val other vent, th	BeC	17. Father's Name (First, Middle,	Last)		1				irst, Middle, M			iteacton
<u>lar</u>		10 E	Leslie Page			•		Margie	e Crab	be			
Maryland	2 sh and and sum	·	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number	er or Rural R	oute Number,	City or Town	, State, Zip	Code)
	1 and 2 Health em 27		David C. Page,	Son	1006	707 L	inden Gr	ove P1	L. #3	Odento	n, Md.	2111	3
altimore,	ages 1 nt of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		m state		sition (Name of natory or other pla	1			20c. Location	- City or To	own, State
<u>#</u>	It. Partmer	, v	4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Met	ropoli		i	1-21-0	·	Lexandi	ria.	Va
Ba	permit. Pages : Department of H Important: If ite any Injury or of		I Wilia 1	Mar	hall	M 4	arshall's 217 9th.	s Fune St. N	ral Ho	ome ashingt	on, D.	.C. 2	0011
L			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that only one cause o	at caused the dea on each line.	th. Do not ent	er the mode of dyi	ng, such as o	cardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aM	atastic	Stomacl	Cancer						Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a consec	quence of):							
-1		er	Sequentially list conditions, if any, leading to immediate cause filer Underlying Cause (Disease or injury	b. Due	to (or as a consec	quence of):						-	
	uted	Examiner	Cause (Disease or injury that initiated events	<b>S</b> .									
o Ô	e exectant an an an an an an an an an an an an an		resulting in death) Last	Due	to (or as a consec	quence of):							
8760,	icate be executed physician and s tha burial-transit	dical		d									
9	ertifica ing ph e as t	Med	IF FEMALE:										
. Box	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome pf pregn /e birth 2 ☐ Fet egnant at time of	al death 3	Ectopic pregnanc	y				ate of delive onth	ery Day Year
o.	the de	ıysic	1□Yes 2□No 9□Unknown		nknown	deam 5L	Other (specify) _						
Д.	w requires that the d been signed by tha should be detached	y Ph	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?
Records,	quires n sign uld be	ed by								1 □ Ye	s 2□No	3 ☐ Prob	oably 4 <sup>25</sup> Unknown
တ္တ	aw re Is bee 2 sho	Completed								24a. Was an	24b.	Were auto	ppsy findings available impletion of cause of
_		mo								autopsy perform 1 Yes 2	ned?	pnor to co death? 1 ☐ Yes	
Vital	siclan: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	1			7		of Death (C	heck only one			<u></u>
7	Physic this or	To I	1 Yes 2 No			ER/Outpatien	1 JU DOX			5 🗆 Reside			(y)
חכ	ding F	ion:	27. Manner of Death 1 XNatural 5 ☐ Pendir	ng (N	ate of Injury fonth, Day Year)	28b. Time of Injury	Wo		1	. Describe hor	w injury occu	rred	
Division or	death death ctor: y tha	icat	2 Accident investing Suicide 6 Could	not be	ace of injury - At h	nome, farm, str	eet, factory, office	Yes 2□N		Location (Str.	eet and Num	her or Run	al Route Number,
2	after d after d Direc d in by	Certification:	4 ☐ Homicide determ	ined bu	ilding, etc. (Speci	ify)	,,,		2011	City or Town,		Der of Flank	ar riodio rvambol,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,						occurred at the ti						
	the Ho in 24 the Fu	Medical	one)	and m	e basis of examin nanner stated.	ation and/or in	vestigation, in my		th occurred a	at the time, da	ate and place,	, and due t	o the cause(s)
9	To To To To	Σ	29b. Signature and title of certifie	er .	1		29c. Licens			29	d. Date signe		Day, Year)
	4		hace	<del></del>	VID.		D0064	578			11-2	0-07	
	SP		30. Name and address of person Chuando Zhan		•		Print) Rockvil	11e. M	D. 20	850			
C	Sta	te	31. Date filed (Month, Day, Year)	30	Registrar's Sign	ature		171 وتعدم					
	Registr	- 11	NOV 2 1	2007	Acer A	O. Sp	who						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Derek Pastor State of Maryland / Department of Health and Mental Hygiene 2007 39278 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Medical Examiner Derek 1520 hrs Pastor November 19, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or **Funeral** Months Days Min. 28 Director 218-21-5228 Country Maryland August 3. 1979 1XX M 2 F Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Prince George's 1 Yes 2 X No or 28a-f show s 23a or 28a-f shov e notified at once. Ft. Washington death with the Maryland rector 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1702 Shipjack Drive 20744 ā USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, or items Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 XX No Specify: Filipino If Yes, Give Year 3 Widowed Divorced Yes 2 x No specify: permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner <u></u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired? Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 1 yr. Substitute Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cesar Α. Pastor Patricia Devera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aubrey N. Pastor / Wife 1702 Shipjack Drive Ft. Washington, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Resurrection Cemetery 11/30/2007 Clinton, Maryland Other Specify 22. Name and Address of Facility ature of Funeral Service License George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland al 23a. Part. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each ine /Medical Death a. Pulmonary Thromboembolism Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed vsician/Medical signed by the attending physician be detached for use as the burial -UNPENDED AMENDED Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown q Unknown Records, P.O. ᅕ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 Other: 1 🗸 Yes No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Yes 2 No Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

d in by the f

cal

State

Registrar

Laron Locke MD. Assistant Medical Examiner 2007

Homicide 29a. Certifier 1

29b. Signature and title of certifier

and manner stated.

ne and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 20, 2007

DHMH 17 Rev 1/2001

OCME

**ORIGINAL** 

			State of Maryland / Dep		Mental Hygie	ene					
			Togota	ertificate of Death		. No. 2 0 0 7	39279				
Н	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death				
	/Medic		JEROME A. PIERCE SR.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	NOVEMBER	15 2007 4c. County of Death	7:30P <sup>™</sup>				
1	Examiñ	er	6610 GLEN AVENUE	GLENDALE		PRINCE GI					
*	Funeral	32	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs			place (State or Foreign intry)				
b.	Director		215 <b>-</b> 34−3023	Months Days Hours Min	AUGUST 2	1935 WAS	SHINGTON, DC				
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits				
	short short	5					1 ☐ Yes 2 ☐ No				
	the N 28a-1 notiffi	Director	MD PRINCE GEORGE'S GLEND  10e. Street and Number	ALE 10f. Zip Code	10g	. Citizen of What Cou	untry?				
	3a or		6610 GLEN AVENUE	20769		USA					
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White					
9	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at		1 □ Never Married 2 Married 1 1 Yes 2 □ No army If Yes. Give	1 ☐ Yes 2 No Specify:	no moan, etc.,	Specify: BLA					
5-0036	ural";	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	cedent's Usual Occupation	16	Sb. Kind of Business/I					
7	n 72 "nat edica	Completed	(Specify only highest grade completed) (Gir	ve kind of work done during most of wo DO NOT use retired)		bb. Killd of Busilless/f	ridustry				
12	filed withi Hygiene. <b>other tha</b> n e <b>nt, the M</b>	mo	Elementary/Secondary (0-12) College (1-4or 5+) 3yrs AUTO	MOTIVE TRANSMISSI	ON SPEC.	PRIVATE					
ğ	e filed al Hyg other /ent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Ma	iden Surname)					
<u>Ja</u>	should be and Mental s marked o umatic eve	To E	FREDERICK PIERCE	MA	GGIE THO	MAS					
a	2 sho and I is ma		19a. Informant's Name/Relationship (Type. Print)	tiling Address (Street and Number or F	Rural Route Number, C	City or Town, State, Z	ip Code)				
<u>ک</u>	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			O GLEN AVENUE GLE		YLAND 2076 Oc. Location - City or 1					
Baltimore, Maryland 2121	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)							
買			Table and the control (opening)	LE CREMATORY 11/ 22. Name and Address of Facility J		IVERDALE, NS FUNERAL					
Ba	permit. Departr Importa any inj			7474 LANDOVER ROA							
	- N		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardi	ac or respiratory arres	t,	Approximate Interval Between				
4	Physician		Immediate Cause (Final disease or condition Respiratory failure								
J.	/Medical		resulting in death)  Due to (br as a consequence of)	, D 5							
ı	Examiner	_	Sequentially list conditions, b. Zune Cancer	with Brain M	etastasis	5					
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	xecul	Examiner	that initiated events resulting in death) Last C								
8760	certificate be executed rding physician and ise as the bunal-transit		Cd								
9	tificate ig phys as the	edi									
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□ Fetal death	3 □Ectopic pregnancy		23d. Date of deli					
	0 0	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  in the past 12 months? 4 □ Pregnant at time of death 9 □ Unknown	5 ☐ Other (specify)		Month	Day Year				
P.0	The law requires that the de tte has been signed by the s lage 2 should be detached 1		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	.cco use contribute to	the cause of death?				
Vital Records,	signe d be o	d by	g	, , , , , , , , , , , , , , , , , , , ,	1 ☐ Yes	2 No 3 Pro	obably 4 Unknown				
S	w require been sit shoutd b	ete			24a. Was an	24h Were au	topsy findings available				
æ	he lav e has age 2:	Completed			autopsy performe	prior to d	completion of cause of				
ā		Be Co	25. Was case referred to medical	26. Place of D	1 Yes 2 eath (Check only one)		2 <b>₺</b> №				
	ysici iis cer direct	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpat	Other:	Home 5 A Residen		cify)				
0	Attending Physician: ir death. ector: After this certific. by the funeral director, I		27. Manner of Death 12 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how	injury occurred					
20	tendi leath. tor: A the fu	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No							
Division or	or Attendatter death Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,				
_	Hospital or / 14 hours after Funeral Dire tely filled in b		29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and pla	ce, and due to the cau	use(s) and manner as	stated.				
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or one) and manner stated.	investigation, in my opinion, death oc	curred at the time, dat	te and place, and due	to the cause(s)				
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month					
•	6		1 Jusquel	D-1925	>0	11-20-	01				
	21		30. Name and address of person who completed cause of death (Item 23a) (Typ JAE CHUNG 9470 ANNAPOLIS RO		ΜΔΡΥΙΔΝΌ 2	0706					
	%X, Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
	Registr		NOV 2 1 2007 Grand D. Sparke								
			100								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Please Type or Print in Black Indelible Ink. Ensure All Co	pies Are Legible
For	State of Maryland / Department of Health and Menta	al Hygiene?
1 State	Certificate of Death	Reg No

	-	For State (		artment of He ertificate of D	ealth and Mental Hy Death	/giene2007 39280 Reg. No.
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Ruziski Wolford Pursch			2. Date of Do Month Nov 19	Day Year
Examin Funeral		4a. Facility Name (If not institution, give street and not washington Adventist House Social Security Number 6. Sex	ospital 7. Age (In yrs. last birthday	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	a Park  If Under 24 Hrs. 8. Date of Bit (Month, D	Montgomery irth ay, Year)  9. Birthplace (State or Foreign Country)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marhail Hygiens 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marhail Hygiens 1 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince George  10e. Street and Number  3100 Upshur Street  11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced  15. Decedent's Education  (Specify only highest grade completed)	aughter 19b. Mai 3100 Place of Discemetery, or Ft. Linco	ainier  10f. Zip Code 2071.  Was Decedent of His If Yes, specify Cubar  1 Yes 2 No  edent's Usual Occupa e kind of work done di DO NOT use retired)  Feacher  Upshur S  consition (Name of ematory or other place	18. Mother's Name (First, Middle Mary McDonal and Number or Rural Route Num treet, Mt. Rain Date y) 11/24/07	10d. Inside City Limits  ★ Yes 2 No  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc. Specify: White  16b. Kind of Business/Industry  Education e, Maiden Surname)  Ld  ther, City or Town, State, Zip Code)
Physician /Medical Examiner phrial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	caused the death. Do not e		g, such as cardiac or respiratory	Approximate Interval Between Onset and Death  Mattsville, MD 20781  Approximate Interval Between Onset and Death
the death certifica the attending ph	Physician/Med	23b. was decedent pregnant	gnant at time of death 5	B □Ectopic pregnancy		23d. Date of delivery Month Day Year
aw requires that the de s been signed by the 2 should be detached	Completed by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause give	1 [ 24a. Wa	d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  as an  24b. Were autopsy findings available prior to completion of cause of
lor Attending Physician: The law requires that the death certificate after death.  Director: After this certificate has been signed by the attending phys d in by the funeral director, page 2 should be detached for use as the	Certification: To Be Comp	27. Manner of Death  Natural 5 Pending investigation 3 Suicide 6 Could not be 28a. Da  (Minute of the could not be could n	Inpatient 2 ER/Outpatite of Injury 28b. Time Injury 28c of injury - At home, farm, sliding, etc. (Specify)	of 28c. Injury Work	Per 1	rformed? death? 21X No 1 ☐ Yes 2 ☐ No
To the Hospital or Attending within 24 hours after death within 24 hours after death or To the Funeral Director; After completely filled in by the funeral	Medical Co	(Check only 2 Medical Examiner: On the	basis of examination and/or anner stated.	29c. License	pinion, death occurred at the tim	ne cause(s) and manner as stated.  le, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) Registrar

Abraham Dabela, MD

32. Registrar's Signature

4404 Queensbury Rd, Riverdale, MD

**ORIGINAL** 

State Registrar

To the

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03:09 November 2007 Patricia Ann Proctor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Yrs Director March 16, 1931 Washington, DC 579-40-5713 76 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Maryland Prince George's Director Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 United States 4707 Deanwood Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Specify: African 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Completed by 3 → Widowed 4 □ Divorced American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 years (1-4or 5+) Maintenance Worker Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hezekiah Sharpe Alberta Woodland ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Proctor - Daughter 4707 Deanwood Dr. Capitol Heights, MD 20745 Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Nov 23, 2007 Clinton, MD 4 Donation 5 Other (Specify) Lee's Crematory 22. Name and Address of Facility Stewart Funeral Home, f Funeral 3, rvice Literal 4001 Benning Road, NE Washington, DC 20019 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, exheart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Insulin Dependent Diabetes Mellitus attending physician and for use as the burlal-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 1 ☐ Yes 2 🖾 No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? res 2 No page 2 s has this certificate 10 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Thopatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending investigation Iniury or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Ophne11 Cumberbatch 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

3001 Hospital Drive Cheverly MD 20785 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 - State Amend Item		Marylar verb.	nd / Depa , <b>g87</b> / <sub>6</sub>	trimen	t of H	ealth a	and M			007	3 9	3283
Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 11 26 2007								ar	me of Death			
/Medi		Ida Wiggins Pritc		ther)		4h City	Town or	Location	of Death	11		County of D		:15 A
Examir	ier	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Millington						JI DOMIN			Queen Anne's			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr					24 Hrs. Min.	8. Date of B	irth 9 Bi			State or Foreig		
Director		210-20-/109	□M 2対F	95	Yrs.	MOTHERS	Days	Hours	WHITE.	09/1/	912	Ma	rylan	d
land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. fns	ide City Limits
Mary I-feh	tor	MD Oueen Ann	ne's	Che	sterto	พท							1 0	]Yes 2⊠N
or 28g	Director	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What	Country?	
23a d		2124 Pondtown Rd				216	20_				USA			
er dek Iteme	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Vas Deced I Yes, spec	dent of Hi offy Cuba	spanic Ori	gin? (Spe i, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W	merican fndi /hite, etc.	an,
rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Give Year or Da	9		□Yes :	2 <b>√</b> No	Specify:				Specify:	31ack	
172 hours after death with the Maryland "nature!", or items 23a or 28a-f ehow adical Examinational be notified at	ted	15. Decedent's Ed	ucation	-	16a. Deced	lent's Usua	al Occupa	ition			16b. K	ind of Busine	ss/Industry	
- X	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-	4or 5+)		kind of wor DO NOT us			t of worki	ng				
7 6 5 7	Con	11			Produ	ction	Wor				1	d Prod	luctio	n
4 5 5 V	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	Sumame)		
2 should be f and Mentai h is marked of reumatic eve	ဥ	George Wiggins  19a. Informant's Name/Relationship (7)	iron Brintl		10h Mailin	- Addr.		Mary		/ Clauda Alumi	C'h	Town Ctr	- 7:- O-d-1	
s 1 and 2 should 4 Health and Men Item 27 is marke other traumatic		Patricia Warner	yp <del>a</del> , r min							<i>i Route Numi</i> Stertow				
is 1 and 2 of Health a litem 27 is other trai		20a. Method of Disposition		20b. F	Place of Dispo					ate		ocation - City		ate
Pages nent of nrt: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		late	Pleas			1	2/1/	2007	Pond	town.N	m	
permit. Pages Deportment of Important: if its any injury or of one.		21. Signature of Funeral Service Licen	see		22	Name an	d Addres	s of Facilit	V					
8978		Jun Tellar			<u>5</u>	70 W.	Cypr	ess S	st. N	& Newn	ton,	MD 216	551	
Medical Examiner  physicien and the purial-transit	cal Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (c	or as a consequence as	uaries of):									
t the death certific by the ettending pached for use as	Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown	4□Pregna 9□ Unkno	th 2 ☐ Feta int at time of d wn	ll déath 3□ leath 5□	Ectopic pro	ecify)					23d. Date of Month	delivery Day	Year
sign d be	by	Part II. Other significant conditions of	entributing to de	ath but not res	ulting in the ur	iderlying ca	ause give	n in Part I.				use contribute □ No 3 □		e of death? 4 @Unknown
The law ete has t page 2 s	Completed	Bothy Marizo	<u></u>						_	24a. Wa: auto perf 1 \( \text{Yes}	psy ormed?_	prior	to completion	dings available n of cause of
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:			_	Othe	~		(Check only	_		Daught	erte
Phys r this sral dia	2	1 Yes 2 No	1 📙 In		ER/Outpatien 28b. Time of		A	4 🗆 Nu		ne Janes 18d. Describe		6 Other (S		ome .
Attending r death. ector: Atterby the fune	ation	27. Manner of Death  1					Work?							
tai or Attend s after death al Director: ,	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Numbe							Number,					
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one) Certifying Phy	rsician: To the tiner: On the ba	sis of examina	wledge, death tion and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the	cause(s)	and manner I place, and o	as stated. Jue to the ca	use(s)
To To	Σ	29b. Signature and title of contifier	5/			29c	License					te signed (M		
		1/ Milel	5			\	UU	066			11	1471	07	
		30. Named and address of person tho of	omplered cause		)23a) (Type.	Print)	2	Cl	ور ر	rlow	1	16-21	160	0
	te	31. Date filed (Month, Day, Year)		gi ar's Signa	iture									

DHMH 17 Rev 1/2001

4a, 10e, 26

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / De	partment of Hea	alth and Mo	•	711111	39284			
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  PRONICA  ROZA  4a. Facility Name (If not institution, give street and number)	VSKI 4b. City, Town, or Lo	/	2. Date of Death Month VOVEMBO	Day Year  216 200  4c. County of Dea	3. Time of Death  4 530 p M			
\$ 'K''	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 166–22–0854 79 Yrs.	Months Days	MA PA	8. Date of Birth (Month, Day, Ye Jul 27, 19	4NNE 9. Bir 28 Per	thplace (State or Foreign ountry)			
e Maryland	e Maryland Ba-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or MD Anne Arundel Seve			10d. Inside City Limits 1 ☐ Yes 2 ※ No					
	ath with the 23 or 21 well be no	ral Dire	614 Kensington Avenue		146		Citizen of What Co				
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show deal Examinar must be notified at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	3. Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes 2 ☑ No 3	anic Origin? (Spec Mexican, Puerto F Specify:	city Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during the NOT use retired Homemakes	ing most of workin	g 16t	16b. Kind of Business/Industry  Home				
Maryland	ould be file Mental Hy wrked oth	To Be (	17. Father's Name (First, Middle, Last)  James Somers	18. Mother's Name (First, Middle, Margaret Shee							
Baltimore, Mar	1 and 2 sh Health and em 27 is m Ithar traum		Joan Motsco/Daughter 61	uiling Address (Street and  4 Kensingtor  position (Name of	n Avenue	Severr	ity or Town, State, .  la Park, !  Location - City or	MD 21146			
	artment of ortant: If it injury or of		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Cemetery, c Metro	rematory or other place) Crematory	Nov. 200	7	Baltimore	e, MD			
Ba Ba	Dermi Depa Impo any ir		Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146								
*	Physician /Medical Examiner	2	Immedia: Cause (Final disease or condition resulting in death)  a	DEN				Interval Between Onset and Death			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	d								
.O. Box 6	the death certific y the attending pl ched for use as t	Physician/Med		Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 2 ☐ No 23c. If yes, outcome of pregnancy 1 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								
al Records,		Completed				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of			
of Vital	Phys this ral dii	To Be	25. Was case referred of medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpate 27. Mannag of Death 28a. Date of Injury 28b. Time	ent 3 DOA Other:		e 5 🗆 Residence	e 6 ☐Other (Spe	cify)			
Jivision or Attending	or Attending ifter death. Director: Afte in by the fune	Certification:	27. Manner Death   Natural   5   Pending   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No   28d. Describe how injury occurred   2								
	Hospita 4 hours Funarai ely fille	Medical C	29a. Certifier (Check unity one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examilier. On the basis of examination and/or and manner stated.	ath occurred at the time, of investigation, in my opinion	date and place, are	nd due to the cause at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)			
	To the To the Complet	M	29b. Signature and title of certifier	29c. License nu	umber 6360	29d. N	Date signed (Mont	h, Day, Year)			
(	412		30. Name and address of person who completed cause of death (Item 23a) (Type MICHAEL A MICROM MD 81	OVETERANS	SHIGHN	Ay Mil	LEPSVILLE	n, Day, Year) 2/8/2007 MDZ1108			
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature NOV 2 0 2007	berte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended iten state Registrar #1, per phys., 11/26/07, BA Certificate of Death<sub>WCHD</sub> 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23 Bosewll Glenn Roy, Jr. Boswell Glenn Roy, Jr. 2007 5:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harrison House Worcester Snow Hill 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yei 6/22/1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F 229-16-1767 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Camelot Circle 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White <u>გ</u> 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Transit Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Boswell Glenn Roy, Sr. Mimi Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff Roy / son 85 Camelot Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: Iff any injury or once, Cape Henlopen Crem. 11/26/2007 Frankford, DE 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Li 108 William St., Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** (erebrovase disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4⊡Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 autopsy performed? Yes 22 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 11-23-07

BA 4+1

State 31. Date filed (Month, Day, Year)

Registrar NOV 2 6 2007

1604-Market

7. Poco noke
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Steven & Spark

State Registrar 30. Name and address of person who compl

31. Date filed (Month, Day, Year)

James

Jarboe

NOV 28

M.D

DHMH 17 Rev 1/2001

24035 Three Notch Road, Hollywood, Maryland 20636

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			riease	ype or Print in E			-			
			For State	State of Marylan	•	nt of Health and I te of Death		21111	39287	
			Registrar  1. Decedent's Name (First, Middle, Lass	*1	Certifica	le Oi Dealii	2. Date of Dea	eg. Nof— U U /	3. Time of Death	
	Physici Medic		Joy	ce	Rida	dick	Month	Day 2007	4.30 PM	
	Examin	er	4e. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Death	1	4c. County of Deet	h /i	
	uneral irector		5. Social Security Number 6. Se 577-68-0498	7. Age (In yrs.	last birthday) If Under Months  Yrs.	or 1 Year   If Under 24 Hrs.   Days   Hours   Min.	8. Date of Birth (Month, Dey	7 9. Bin	hplace (State or Foreign nuntry)	
ryland	how		Usual Residence of Decedent  10a. State  10b. County	10c. Cit	y, Town or Location	1 11	11.		10d. Inside City Limits	
death with the Maryland	r 28a-f e	Director	MD PRINC	e George	Dist.	rict Heig	hts	0g. Citizen of What Co	1 Yes 2 No	
eath with	ns 23a o must be	Funeral D	2306 K	05/UN/ 12. Was Decedent Ever in U	4Ve	26747	pecify Yes or No-	US	nican Indian,	
OUSO hours after d	of other than "natural", or itams 23a or 28a-f show event, the Medical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  ↑ Armed Forces?  ↑ Armed Forces?  No If Yes, Give Year or Dates:	If Yes, spo	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert  2 No Specify:	o Rican, etc.)	Black, Whit		
2 0	n "nature Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usi (Give kind of w life. DO NOT	ork done during most of wor	king	16b. Kind of Business	•	
a Z 1 Z 1 filed within Hvaiene.	4 4	Con	- Call - 25 / 25 / 75 / 75 / 75 / 75 / 75 / 75 /	2	FEDERI	AL GOV4 el	nployee		VICE	
	of Health and Men If item 27 is marke or other traumatic	To Be	17. Father's Name (First, Middle, Last) Winford	Smith		18. Mother's Nan	ne/(First, Middle,	Alste	ON MANA	
2 0			19a. Informant's Nam Pelationship (7)	Riddick/S	19b. Mailing Addres	s (Street and Number or Rule ROSIUN	AVE L	OSTRICIS	HEIGHTS HL	
es o			20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	Place of Disposition (National Place of Disposition (National Place)	other place)	Date //24//-	20c. Location - City or	Town, State	
<b>SAITIM</b> permit. Pag Department	Importan any injury once.		21 Signature of Funeral Service Licens		22 Name a	and Address of Facility	16.000	580	1 Cleveland	
			23a. Part 1. Enter the see se, or comp shock, or heart fallure. Link only c	elications that caus—the deat one cause on each line.	h. Do not enter the	de of dying, such as cardiac	or respiratory are	est,	Approximate Interval Between	
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	a. Metasta	tic Caner	Uterus			Menify	
Exa	attending physician and Survive as the burial-transit	er	Sequentially list conditions,	b. Due to (or as a conseq	uance of).					
/ oU, te be executed		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):					
		cai		d						
Geath certificat		Physician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of de		
	by the ache	hysici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown				Month	Day Year	
COLDS, P.O	has been sign je 2 should be	by	Part II. Other significant conditions co	entributing to death but not res	ulting in the underlying	cause given in Part I.		3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown		
a §		Completed					24a. Was a autop perfor	sy prior to med? death?	utopsy findings available completion of cause of	
		0	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes ath (Check only or		: 2□ No	
93	S .	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2	ER/Outpatient 3 D			ence 6 Other (Spe	cify)	
On OT Iding Phy	s within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h			
DIVISION  I or Attending after death.		Certification:	3 Suicide 6 Could not be 4 Homicide determined	ome, farm, street, facto y)	ry, office	28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number City or Town, State)			
Hospita 24 hours	Funeral stely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Phy	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurrention and/or investigation	d at the time, date and place n, in my opinion, death occu	e, and due to the corred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)	
o the	o the	Me	29b. Signature and title of centifier		29	9c. License number	2	29d. Date signed (Mon	h, Day, Year)	
iC	J		> Ashisatar	MD		D0053411		Nov. 201	2007	
	3)		30. Name and address of person who of 14300 Gallant Fo	x Ln # 210	Bowne	J Shesa MD 2				
9	Sta Registr		3 NOV 2 1 2007 (Agricant 2007)	32. Registrar's Signa	ature					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan		artment of rtificate of		_	giene Reg. No.	2007	39281					
	Physici /Medi		1. Decedent's Name (First, Middle, L ELIZABETH	ROGERS	<b>,</b>			2. Date of De NOVEMB	ER Day		3. Time of Death 20:45P M					
	Examir	er	UNIVERSITY SPEC	4a. Facility Name (If not institution, give street and number) UNIVERSITY SPECIALITY HOSPITAL			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death						
	Funeral Director		5. Social Security Number 6. 238-02-6057  Usual Residence of Decedent	Sex 7. Age (In yrs. 1 M 2 F 53	last birthday, Yrs.	If Under 1 Year   Months   Days			<sup>th</sup> 1954	9. Birthp	place (State or Foreign					
	land ow at		10a. State 10b. County	10c. Cit	y, Town or L	ocation				1	10d. Inside City Limits					
	h the Marylan or 28a-f show ontified at	tor	DC	WAS	HINGTO				Y∏Yes 2 □ No							
	h with the 23a or 28k st be not	al Director	10e. Street and Number 1025 47th PLACE N.E.			10f. Zip Code 20019				en of What Coul	ntry?					
036	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notifled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	.S. 13.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto P			ecify Yes or No- Rican, etc.) 14. Race - Black, N Specify:		American Indian, White, etc. BLACK					
2-0	72 hc 'natuı dical	eted	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dece	edent's Usual Occu	ipation during most of wo	rking	16b. Kin	d of Business/In	dustry					
21215-0036	filed within 72 ho Hygiene. other than "natu ent, the Medical	Completed	Elementary/Secondary (0-12) 12TH	College (1-4or 5+)	College (1-4or 5+)  REGISTRAT				PRI							
Maryland	e d ala	To Be	17. Father's Name (First, Middle, Las ROBERT WHITEH				JANE P	me (First, Middle OLLARD	, Maiden S	Surname)						
lan,	CI (0 0) 63		19a. Informant's Name/Relationship			ing Address (Street and Number or Rural Route										
	s 1 and 2 of Health item 27 other tr	-	LAVONNE ROGERS/													
Baltimore,	Pages 'nent of H		20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or To													
	# 문학등	1	4 Donation 5 Other (Specify)  RESURRECTION CEMETERY 11/10/2007 CLINTON, MARY  21. Signature of Funeral Service Licensee  22. Name and Address of Facility J. B. JENKINS FUNERAL													
	permi Depar Impor any Ir		L. Signature of Full land service Lie	70/			OVER ROA									
	Physician /Medical	V: 0	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. SEVERE POLYMYOSITIS  Due to (or as a consequence of):													
b	Examiner				ANOXIC BRAIN DAMAGE											
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):												
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	U	c. CHRONIC RENAL FAILURE											
8760,	ate be executed thysician and the burial-transit	ca	resulting in death) Last	Due to (or as a consequence of):  d. SEPSIS												
.O. Box 6	ires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transition.	ysician/Me	ysician/Me	ysician/Me	ysician/Me	Physician/Med	ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous p ☐ Unknown	al death 3	B⊟Ectopic pregnancy 23d. Date of deliver Month					ery Day Year
Records, P	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1   Yes   27   No   3								the cause of death? bably 4 □Unknown					
Ö	w requir s been si should I	Completed	THROMBOCYTOPENIA	,				24a. Was	an	24b. Were autopsy findings availa						
	The law ate has b page 2 sh	dwo	PULMONARY HYPERT	ENSTON			<del></del>	auto perfe	ormed?	prior to co death?	mpletion of cause of 2X No					
or Vital		Be C	25. Was case referred to medical				26. Place of De	1  Yes ath (Check only		1 ☐ Yes	<b>₹₹</b> 140					
>	rysici is cer direc	To B	examiner? 1	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	her: 4 \(\sum \) Nursing I	Home 5 ☐ Resi	dence 6	□Other (Speci	Ty)					
0 _	ding Ph n. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		ury at ork?	28d. Describe ho		occurred						
Division	Attending Physician: or death. ector: After this certific by the funeral director,	Certification:	2 Accident   Simple training   Accident   Ac						28f. Location (Street and Number or Rural Route Numb City or Town, State)							
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifying F	Physician: To the best of my kno	owledge, dea			e, and due to the	cause(s)	and manner as s						
	the Hc in 24 he Fu pletel	Medical	one)	aminer: On the basis of examina and manner stated.	ition and/or ii			urred at the time.	, date and	place, and due t	o the cause(s)					
	To t withi	Σ	29b. Signature and title of contifier	The	M	D006	se number			e signed <i>(Month,</i> EMBER 16	**					
	00		30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type,	, Print)										
1	TX.		CORDELIA T. GR	IMM M.D. 611 S.	CHART	ES STREE	T BALTIMO	ORE, MAR	YLANT	21230						

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

NOV 2 1 2007

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 39289

		1- For State Registrar		С	ertificate	of D	eath			Reg	No.		
Physicia		Decedent's Name (First, Midd	le,Last)						2. Date Mon	of Death	Day Year	1	ime of Death
edical Exami		Betty Jane Si	hoop						Nove	ember 2	29, 2007		1857 hrs
		4a. Facility Name (if not institution		umber)		4b.	City, Town, or	Location of	Death		4c. County of		
		505 W. Church Street	t				lagerstowr	1			Washingt	on	
Funeral		5. Social Security Number	6. Sex	7. Age (In yr:	s. last birthda	_	f Under 1 Yea			te of Birth	(MM/DD/YYYY)	9. Birthpla	ce (State or
Director		220-54-4792	1M 2_ <b>X</b> F		59	Yrs.	Months Day	s Hours	Min.	ay 11	, 1948	Country	aryland
	H	Usual Residence of Decedent		1									
any		10a. State 10b. County		10c. C	ity, Town or I	ocation							I. Inside City Limits
rd rd ce	_	Maryland Wa	ashington			I	lagerst	town				1	Yes 2 No
Maryland 28a-f show any d at once	양	10e. Street and Number	-			10	f. Zip Code	_		100	. Citizen of Wha	at Country?	
he Ma	Director	507 W. Church	h Street				2	21740			U.S.A.		
with the Maryland ns 23a or 28a-f sho be notified at once	<u></u>	11. Marital Status		ecedent Ever in	1 U.S. 1				n? ( Specify Ye				Indian, Black,
eath vitem	Funeral	1 Never Married 2 N	farried Armed	Forces?		If Yes,	specify Cubar	n, Mexican,	Puerto Rican,	etc.)	White,		
fter d		3 Widowed 4 X Div	vorced If Yes, Give Ye	ear	´	1 Ye	s 2 No	specify:			Specify:	Whit	e
215-0036 be filed within 72 hours after death with the Maryland null Hygiene. hed other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	d by	15. Decedent's Education (Spe	ecify only highest gra	ade completed		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Bus	iness/Indu	stry
72 ho	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)							D	1 _	
vithin ene.	Ę	10				поі	пешакел					Hal K	esidence
21215-0036 ould be filed within 7 is marked other than ic event, the Medical		17. Father's Name (First, Middle George W.					İ				aiden Surname) <b>Davis</b> J	OBOG	
121 d be f lental arke	Be			•	405.	4-:I: A	Idage (Class				er, City or Town		Codo
D 2 Shoul- and M atic e	٦ ا	19a. Informant's Name/Relation: Brenda Michae		htor	200								ia 25403
imore, MD 2121. Pages 1 and 2 should be filment of Health and Mental I tant. If item 27 is marked or other traumatic event,		20a. Method of Disposition	er daug				n (Name of ce		Date		20c. Location -		
Ore, Nes I and of Health If item		1 Burial 2 Crematio	n 3 Removal	from Choto	crematory	or other	<sup>place)</sup> Cremat	1	12 /	2007	Smi+ha	hura	Maryland
Pag ment tant:		4 Donation 5 Other S			MIL CIIS								
Baltimore, permit. Pages I an Department of He Important: If ite		21. Signature of Funeral Service	e Licensee				e and Addres						ral Home and 21742
		23a. Part I. Enter the disease	affar	ON	ath Danata					_			pproximate Interval
Physician 'Medical		failure. List only one cause	e on each line.					, 30011 63 06	raide or respir	atory arro	, o ( ) o o o o o o o o o o o o o o o o o	E	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)		cations of		one hi	ritis	_				-1	
			h	a consequenc	e orj.								
	ē	Sequentially list conditions, if any, leading to immediate		a consequenc	e of):								
9 .	Examiner	(Disease or injury that initiated Due to (or as a consequence of):									<del></del>		
and transit	Exa	events resulting in death) Last	Due to (or as	a consequenc	; UI).								
exec	ca	X UNPENDED	AMENDED	)	-		- 1 1						
760, ficate be ex g physician s the burial	edi		#23a.	PII.27.p	erME.g8	74. 1	2/24/ <u>07</u>	TT			23d. Date of	delivery	
876 fical	2	IF FEMALE: 23b. Was decedent pregnant in			2	Fetal	death 3	Ectopic	pregnancy		Month	Day	Year
Sox 687 leath certifide attending for use as t	icia	past 12 months?		gnant at time o			(Specify)				Î		
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medical	restantia con percenta de la composición dela composición de la composición dela composición de la composición de la composición de la com		nown									
- 후 등 등 등	by P	Part II. Other significant condi						given in Pa	rt I. 23				cause of death? y 4 ✓ Unknown
F. P.C irres that signed l	d b	<u>Hypertensive at</u>	<u>herosclerot</u>	<u>ic cardi</u>	ovascul	ar di	sease	-	56				
ords, w requir s been s should	Completed								24	4a. Was a autops	y p	rior to com	sy findings available pletion of cause of
Reco The law cate has	Ĕ									✓ perform		leath? ✓ Yes	2 No
tal Recian: The		25. Was case referred to medic	al		_		26.Plac	e of Death (	(Check only on				
Vital   ysician: his certif director,	Be c	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outp	atient 3	DOA	Other <sub>4</sub>	Nursing Hom	e 5	Residence 6	Other: So	cene
n of Vital Records, ing Physician: The law requir After this certificate has been s tuneral director, page 2 should 1	Ϊ	27. Manner of Death	28a. Da	te of Injury hth, Day,Year)	28b. Tir	ne of Inju	ry 28c. Inj	ury at Work	? 28d. E	Describe h	ow injury occurr	ed	
_ = ~2	tion		nding	ntn, Day,Year)			1_	Yes 2	No				
Division tal or Atteudir rs after death. al Director: A led in by the fu	ica		estigation 28e. Pla	ace of Injury - A	At home, farm	n, street,	factory, office	building, etc				er or Rural	Route Number, City
Divis pital or At ours after d	Certification: To		ermined (Specif	ý)					0	r Town, St	ate)		
Division of Vital F To the Hospital or Attending Physician: within 24 hours alret death. To the Funeral Director: After this certifit completely filled in by the funeral director,		29a. Certifier 1 Certifying F	Physician: To the b	est of my know	/ledge, death	occurred	at the time,	date and pla	ace, and due to	the cause	e(s) and manner	as stated.	
To the I within 2 To the I complet	Medical	one) 2 • Medical Ex	aminer:On the basi	s of examination	on and/or inv	estigation	n, in my opinio	n, death oc	curred at the ti	me, date a	and place, and d	ue to the c	ause(s)
To with	Me	29b. Signature and title of certif		1			29c. Licer	se number			29d. Date sign	ed (Month,	, Day, Year)
		Cals:11	11	11	7		0.0	.M.E.			November	30, 200	7
		30. Name and address of perso	n who completed ca	ause of death (	Item 23a)	~							
		Pamela E. Southall,		t Medical E		111	Penn Stre	et, Baltim	ore, MD 2	1201			
S	tate	31. Date filed (Month, Day, Year	7 2007 32.	Kegistrar's Sig	natur	(1)00							
Regis		TIEL U	7 2007	- Balling	-								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 18, 2007 Lorayne Anita Schmitman 11:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 302 Gordon Avenue Severna Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛣 F 83 335-16-0918 16,1924 Director Illinois Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Anne Arundel Severna Park Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 USA 302 Gordon Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker/Secretary Home/Administrative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Minowicz Charles Cole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 Holly Grell/Daughter 302 Gordon Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & 495 Gov. R Severna Park Funeral Home Severna Park, MD 21146 Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listlonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 17hemer gars **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physiclan and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical ed by the attending p detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attended within 24 hours after death To the Funeral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) How Hoy Arnold James 31. Date filed (Month, Day, Year) NOV 2 0 2007 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Elizabeth L. Sappington 3:48 A M 17, 2007 Nov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel Pasadena 502 Pasadena Road East If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 F 30 220-16-7705 9, 1927 Maryland Feb. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director MD Pasadena Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number l or ns 23a must b 21122 USA 502 Pasadena Road East Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or the 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 22 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Administration <u>Executive Secretary</u> other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Sarah Acree Herman M. Lewis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD 21122 Herbert L. Sappington/Husband 502 Pasadena Road East 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or of Nov. ™ Burial 2 ☐ Cremation 3 □ Removal from State Important: If any Injury or Glen Burnie, MD Glen Haven Memorial 2007 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Funeral Service Ligense Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 Part . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** inchosis /Medical Due to (or as a consequence of): Examiner Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 PNo 24a. Was an page 2 s autopsy 2**/2** No 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) ၀ 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature apd itle of certifier MD ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a Road Glen Burnie 7845 OAKWOOL Moneres Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

**Physician** /Medical **Examiner** 

**Funeral** Director

show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages

**Physician** /Medical Examiner

The law requires that the death certificate be executed attending physician for use as the buris page 2 this or Attending after death

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) Isabell Saunders 11:34AM 2007 November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 46169 Pleasant Road Lexington Park St. Mary's Social Security Number 7. Age (In yrs. last birthday)
74 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🛛 F Months Days Hours 214-32-9747 Maryland August 4, 1933 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland St. Mary's 1 ☐Yes 2X No Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46169 Pleasant Road 20653 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Black Specify: 3 ☐ Widowed 4 N Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Custodial Worker 12 iges 1 and 2 should be filed very filed wit of Health and Mental Hygic If item 27 Is marked other in the m 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Saunders Sadie Monique 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Carter / Son 9121 Old Burton Circle Upper Marlboro, MD 20772 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. November 29 Zion Cemetery Mt\_ 4 Donation 5 Dother (Specify) St. Inigoes, Maryland 2007 21. Signatu e of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart Due to (or as a consequence of) pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or A a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 6lestro 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2⊠ No filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours at 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAE T. AUNG MD. 24435 M4



MERVELL

DEAN RD, HOLLYWOOD MD2063

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours a To the Funeral C

29b. Signature and title of certifier

Road

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed/c ause of death (Item 23a) (Type, Print)

James P. Jarboe, M.D. Hollywood, MD 20636

24035 Three Notch 31. Date filed (Month, Day, Year) State NOV 2 6 2007

32. Registrar's Signature

Registrar

7-08860 acqueline Stutt		Please Type or Print in Black Indelible Ink. Ensure All Co State of Maryland / Department of Health and Menta 1- For State Certificate of Death	
Physici	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death 3. Time of Death
ledical Exam	iner		November 15, 2007 0642 hrs
		4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital  4b. City, Town, or Location of Clinton	Death 4c. County of Death Prince George's
Funeral Director		5. Social Security Number 5.5.2-4.7-8.500 6. Sex 1. Months Days Hours	24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)  3/20/77 CALIFORNIA
id how any ce.	_	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   PRINCE GEORGES   CLINTON	10d. Inside City Limits 1 X yes 2 No
larylar 18a-f s at on	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
the M sa or 2		9502 SILVER FOX TURN 20735	USA
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, and "items 33a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, If	n? (Specify Yes or No- Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
s after rral",	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give ki	Specify: BLACK
2 hour "nate	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
036 ithin 7 ne.	uple	2 ACCOUNTANT	LAW FIRM
5-0036 led within 7 Hygiene. I other than			Name (First, Middle, Maiden Surname)
121 d be fi lental ] arked	Be	JARED L. STUTTS MAR	CELLA GOSS
MD 21 d 2 should Ith and Mer n 27 is man	2		per or Rural Route Number, City or Town, State, Zip Code)
and 2 lealth tem 2 tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	X TURN CLINTON MD 20735  Date 20c. Location - City or Town, State
DOFE ages 1 nt of H t: If i		1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEM.	11/26/07   CLINTON,MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 3	4   Donation 5   Other Specify:	STRICKLAND FUNERAL SERVICE
Ba Perm Depu	d	Kenya & Strwart 6500 ALLENTON	WN RD. CAMP SPRINGS, MD 201
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cal failure. List only one cause on each line.	rdiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical aminer	0.01	Immediate Cause (Final disease a. Cardiac arrhythmia	Death
,2		or condition resulting in death)  Due to (or as a consequence of):	
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
rd sit	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
executed an and al - trans	la E	d.	
6 be e ysicial burial	ed j	X UNPENDED #23a,27, perME, g874, 12/24/07 TT	23d. Date of delivery
Box 68760 e death certificate by the attending physic ed for use as the bu	<u>₹</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy Month Day Year
ath certain attend	Sici	4 Pregnant at time of death 5 Other (Specify)	
the de	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did tobacco use contribute to the cause of death?
P.O. es that the grand by be detacled	<u>چ</u>		1 Yes 2 No 3 Probably 4 V Unknown
ds, equire een si ould b	Completed		24a. Was an 24b. Were autopsy findings available
COF e law r e has b e 2 sh	훁		autopsy prior to completion of cause of death?
Re I: The ifficate or, pag		25. Was case referred to medical 26.Place of Death (	1 Yes 2 No 1 Yes 2 No
/ita /siciar ois cer directo	Be Be	examiner? Hospital:	Nursing Home 5 Residence 6 Other:
Division of Vital Records, P.O. Box 68760, 4 Hospital or Attending Physician: The law requires that the death certificate be execute Runeral Director: After this certificate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the burial - tran	12	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
ion tendir eath. or: A	itioi	1 X Natural 5 Pending (Month, Day, Teal) 1 Yes 2	No
Division ospital or Attend hours after death, meral Director: y filled in by the f	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc	<ul> <li>28f. Location (Street and Number or Rural Route Number, City or Town, State)</li> </ul>
Di pital ours a reral I	Cert	4 Homicide determined (Specify)	
lospit 4 hour 7uner: ely fill	ပို	29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	ce, and due to the cause(s) and manner as stated.

To the Hospin within 24 hou

Pamela E. Southall, MD Ass State 31. Date filed (Month, Day, Year) Registrar NOV 2 8 2007

29b. Signature and title of certifier

Assistant Medical Examiner

32. Registrar's Signatur

A. Approximately 1.

who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 16, 2007

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please	Type or Print				-	_	
For State Registrar	State of Mary		ment of Health licate of Deat		-	ene g. No.O A A 77	20205
1. Decedent's Name (First, Middle, Las					Date of Death     Month		3: Time of Death
4a, Facility Name (If not institution, give	RNER DAMPE	41	City Town or Location	n of Dooth	11	14 2007	12:57 AM
1	wist Hor	I	o. City, Town, or Locatio	7	24.	4c. County of Deat	Cowersy
5. Social Security Number 6. Social Security Number 1	ex 7. Age (III	yrs. last birthday) if	Under 1 Year If Und onths Days Hours	er 24 Hrs.	8. Date of Birth (Month, Day,		hplace (State or Foreign untry)
Usual Residence of Decedent		87			Jan. 1,		inburg, N.C.
10a. State 10b. County		c. City, Town or Location					10d. Inside City Limits
Maryland Prince	Georges	College Pa			10	on Citizen of Milest Co	1 Yes 2 No
8006 -54th Ave.			0f. Zip Code 20740		16	g. Citizen of What Co United S	
11. Marital Status	12. Was Decedent Ever	in U.S. 13. Was	Decedent of Hispanic (	Origin? (Spec	cify Yes or No-	14. Race - Ame Black, Whit	rican indian,
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2√ No Speci		nouri, oto.)	Specify: B]	
15. Decedent's Ed	ucation	16a. Decedent	's Usual Occupation		1	6b. Kind of Business/	Industry
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	d of work done during m NOT use retired)	ost of workin	ng		
6th 17. Father's Name (First, Middle, Last)		Trucl	C Driver	ther's Name	(First Middle M	Private   aiden Surname	
Daniel Lee Turne	r			en Dou		all of the state of	
19a. Informant's Name/Relationship (7			ddress (Street and Nun				
Sarah Worthy Tur  20a. Method of Disposition			64th Ave. C				
1 Donation 5 Other (Specify	nemoval from State	Ob. Place of Disposition cemetery, cremate Lincoln Me		11/21	10007	Oc. Location - City or	
21. Signature of Funeral Service Licen						Suitland,	
fattha. Sa	12/010100	Pr 5:	ame and Address of Fac Lexander, S. 38 Marlbor	o PPP &	/Forest	ville, Md.	20747
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.		e mode of dying, such	~		st,	Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a co	nsequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence of):			-		
that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					
	d						
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p					23d. Date of del	ivery
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown		opic pregnancy her (specify)			Month	Day Year
Part II. Other significant conditions of	ontributing to death but no	t resulting in the under	lying cause given in Par	rt I.	23e. Did toba	acco use contribute to	the cause of death?
HYPERTENSION	·				1 ☐ Ye	s 2 No 3 Pr	obably 4 Honknown
- DIMIGE					24a. Was an autopsy perform	ed? death?	atopsy findings available completion of cause of
25. Was case referred to medical examiner?	Hospital:	/		ce of Death	(Check only one		
1 Yes 2 16  27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	28b. Time of	Other: 4 28c. Injury at Work?			nce 6 Other (Sperior occurred	cify)
2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, street,	M 1 ☐ Yes 2 [ factory, office		8f. Location (Str. City or Town,	eet and Number or Ru	ıral Route Number,
29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Examone)	vsician: To the best of m iner: On the basis of exa and manner stated.	y knowledge, death oc mination and/or invest	curred at the time, date igation, in my opinion, d	and place, a leath occurre	nd due to the ca ed at the time, da	use(s) and manner as ite and place, and due	s stated. e to the cause(s)
295. Signature and title of certifier	W.D		29c. License numbe		29	d. Date signed (Mont.	

100 State Registrar

31. Date filed (Month, Day, NOV 2 1 2007

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Canall

32. Registrar's Signature

		1 - For State Registrar	State of Ma	aryland / Depa	artment of F		nd Mental H	21	007	39296
	- F	Decedent's Name (First, Middle,	Last)		timouto or i	Doutin	2. Date of D	Reg. No.	001	3. Time of Death
Physic /Medi	cal÷		N CHI TUMAN.	JONG			Month NOV	18 <sup>Day</sup> 2	007	3:32 P
Examir	ner	4a. Facility Name (If not institution,	,	ENGED	4b. City, Town, or		Death		nty of Death	
		NATIONAL NAVA  5. Social Security Number 6		ENTER e (In yrs. last birthday)	BETH If Under 1 Year	ESDA If Under 24	Hrs. 8. Date of B		MONTGO	
Funeral Director		804-62-6139	404 005	75 Yrs.	Months Days		Min. MARCH	15 193	2 Cam	place <i>(State or Foreigntry)</i> I <b>eroon</b>
pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	action					
e Maryla a-f sho	ctor	MD Freder	ick	Frede						10d. Inside City Limit 1 HYes 2 □ N
with the	Director	10e. Street and Number 122 Missouri Co	urt		10f. Zip Code 2170	12		10g. Citizen	of What Cou	ntry?
Jeath ms 23	Funeral	11. Marital Status	12 Was Decedent F	Ever in U.S. 13.			n? (Specify Yes or N		Race - Ameri	can Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1	40	lf Yes, specify Cuba 1 □ Yes 2 <b>X</b> □ No	an, Mexican, I Specify:	n? (Specify Yes or N Puerto Rican, etc.)		Black, White,	
72 hou 'natura dical E	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup- kind of work done of	ation during most o	of working	16b. Kind o	of Business/Ir	dustry
within ene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done co DO NOT use retired UPERINTEN			GO	VERNME	יזאי
filed Hygi other ent, t	ပ္	17. Father's Name (First, Middle, La			OI BICERTER		s Name (First, Middl			17. T
Duld be Mental arked o	To Be	ANYEZA TUMAN	JONG			NDZV	VENG ZAMAN	NIBA		
id 2 sh Ith and 27 Is m traum		19a. Informant's Name/Relationship BERNARD TUMANJON	, , ,				or Rural Route Num		.,, -,	/
Heal Heal tem 2		20a. Method of Disposition	G/ SUN	20b. Place of Dispo	sition (Name of		FREDERICK,		ND 217 on - City or To	
Pages lent of nt: If it	Ш	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		FAMILY P	natory or other plac		2/3/2007		DE, CAM	
permit. Departm Importa any inju once,		21. Signature of Funeral Service Lic		22	2. Name and Addres	ss of Facility	J. 3. JI	1		
9 3 1 6	9 3	MINDERVE	and	7	474 LANDO	VER RC	AD LANDOV	ER, MAR	YLAND	20785
Physician /Medical Examiner bhysician and physician and the prijal-transit the prijal-transit case of the prijal-transit case of the physician and physician and physician are provided the physician and physician are provided to the physician and physician are provided to the	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence of): a consequence of):	STATE CA	NCER				Onset and Death
death certificate be attending physic	an/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d		Ectopic pregnancy			23d.	Date of deliv	•
the dea y the al	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		Other (specify)				Month	Day Year
w requires that the de been signed by the s should be detached	Completed by Physician/Me	Part II. Other significant conditions	s contributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.		tobacco use c		he cause of death?
E 25.0	plete						24a. Wa:	s an 24	lb. Were auto	ppsy findings available mpletion of cause of
(G L)	5						peri 1∐ Yes	formed?	death? 1 ☐ Yes	
Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					Death (Check only	$-\Delta$		
g is ×	ှ	1 ☐ Yes 2 💢 No	Hospital: 1 X Inpatier	<del>_</del>		7 🗆 (140)3)	ng Home 5 ☐ Res	sidence 6 🗆	Other (Specif	(y)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death  1 X Natural 5 Pending  2 Accident investigati  3 Suicide 6 Could not	he i	Year) Injury		rat :? ∕es 2∐No		how injury oc		
tal or Airs after or al Direct led in by	Certifi	4 ☐ Homicide determine		ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office		28f. Location City or To	(Street and Nu own, State)	mber or Rur	al Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying I 2 Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examination and/or in	occurred at the time restigation, in my op	ne, date and pointon, death	place, and due to the occurred at the time	e cause(s) and e, date and place	manner as s ce, and due to	tated. the cause(s)
To the within To the comple	Ž	29b. Signature and title of certifier	1111	1	29c. License	number		29d. Date sig		
10		Waved	H. Cont	O COLM	c_A !			191	10 V 2	00 +
D	-1	30. Name d address of person wh	•				NAVAL ME		CENTER	
Sta	to	DAVID A. KRISTO 31. Date filed (Month, Day, Year)	COL MC 32. Registra	USA r's Signature	BE'.	THESDA	MD 20889	-2600		

DROWN 17 GOV 11/001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

eith Enc william	1- For State Certificate of Death Registrar	Reg. No. 20	3929
Physiciar Medical Examin		2. Date of Death Month Day Year November 27, 2007	3. Time of Death 0824 hrs
,	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Dea	
Funeral	Southern Maryland Hospital Clinton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I if Under 24Hrs.	Prince Georg	
Director	217–08–9596  1 X M 2 F 36 Yrs. Months Days Hours Min.		ign Rota, Spain
d te.	10a. State 10b. County 10c. City, Town or Location MD PG Fort. Washington		10d. Inside City Limits 1 XYes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 10f. Zip Code 20744	10g. Citizen of What Co	untry?
ith the hard		U.S.A.	ariaan Indian Blash
leath w	11. Marital Status 1 Never Married 2 Married 1 Yes 2 X No 1 Never Married 2 Married 1 Yes 2 X No	tican, etc.) White, etc.	erican Indian, Błack,
s after or iral", o	3 Widowed 4 X Divorced in res. Give year or Dates:	Specify:	Black
72 hour n "natu al Exar	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire		s/industry
5-0036 lied within 72 hours afte Hygiene. Other than "natural", the Medical Examiner	Elementary/Secondary (0-12)  12th  College (1-4 or 5+)  To. Decedent's Usual Occupation (Give kind of working life. DO NOT use retire during most of working life. DO NOT use retire Postal Clerk  17. Father's Name (First, Middle, Last)	Federal Gov	emment
VID 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items 23a or 28a-f she on the New York of th	D 77 a 77 1 a a 1 3 7 1	A. Smalls	
D 21 should and Me 7 is man	2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru Barbara A. Williams – Mother 6104 Claridge Road; Temple		ite, Zip Code)
e, MD 1 and 2 sho Health and ritem 27 is	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr	4 Donation 5 Other Specify: Resurrection Cemetery 12/03	3/2007 Clinton, M	aryland
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other transmic event, I	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Free 4594 Beech Road; Temple	eman Funeral Services Hills, Maryland 20	748
Physician 'Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.		Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Occlusive rulmonry embolism  Due to (or as a consequence of):		Death
	Sequentially list conditions, if any, leading to immediate  b. Deep venous thrombosis of the lay  Due to (or as a consequence of):		
	cause. Enter Underlying Cause (Disease or injury that initiated		
cuted ind transit			
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	X UNPENDED  AMENDED PI line a-b, 27 perME, C875, 1/11/08 TT  IF FEMALE: 23c. If yes, outcome of pregnancy		
3876 rrtificate ling phy		23d. Date of deliving Month	ery Day Year
Sox (death ce attend	23b. Was decedent pregnant in the past 12 months?  1		
that the d ned by the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	
ds, F		1 Yes 2 ✓ No 3 P	robably 4 Unknown autopsy findings available
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach		autopsy prior t death'  1 ✓ Yes 2 No 1 ✓	
ital Reician: The certifical rector, pa	b 25. Was case referred to medical 26. Place of Death (Check or		165 2 110
of Vital Recling Physician: The I	O 1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing	Home 5 Residence 6 Ott  28d. Describe how injury occurred	ner:
on of ending Pl ath. or: After the funera	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		
Division ospital or Attending tours after death, neral Director: After filled in by the functions of the filled or the filled or the filled in the filled or	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State)	Rural Route Number, City
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitived Certification.			
F. W. F. S.		29d. Date signed (#	
1	Donna m menti, mo. O.C.M.E.	November 28,	2007
RU	30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, ME	21201	
Stat Registra			

DHMH 17 Rev 1/2001 OCME 2006 Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this

1. Decedent's Name (First, Middle, Last) 2. Date of Death November 7 2007 **Physician** 05:15 John Otto Wiberg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner South River Health & Rehabilitation Center Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/17/1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days 1**X** M 2□ F Michigan 363-38-2809 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. The Medical Examinar must be accessed. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2X1No Director Marvland Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2451 Medford Court 21114 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: <u>م</u> 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Consultant Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Patterson Harold Carl Wiberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma O. Wiberg/Spouse 2451 Medford Court, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/20/2007 Edgewater, Maryland Kalas Crematory 21. Signature of Fulleral Service Licensee 22. Name and Address of FacilityGeorge P. Kalas Funeral Home "Ulla 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the control of the c Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lumone /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending phi for use as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Chawla, 14300 Gallant Fox Lane, Suite 210, Bowie, Maryland 20715 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 10, 2007 **Physician** ZJAM CORA WILLIAMS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CRESCENT CITIES CENTER RIVERDALE PRINCE GEORGE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign | Months | Days | Hours | Min. | SEPT 1 4, 1916 | NORTH CAROL INA 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 🛣 243-24-2738 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1√ Yes 2 No MD PRINCE GEORGE'S FORESTVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2917 PARKLAND DR., 20747 UNITED STATES Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK à 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 9t.h College (1-4or 5+) DOMESTIC DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLOSS BATTLE PEARLIE HINES 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau
once. LENA W. HALL/DAUGHTER 2917 PARKLAND DR. FORESTVILLE, MD. 20747 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD NATIONAL MEM. CEM. 11/16/07 LAUREL, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service 22. Name and Address of Facility D.C. 20002 CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Anthiascle Porce Carrarovascular Disea y-eans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown Were autopsy findings available prior to completion of cause of 24a. Was an Artery Disease onany 1□ Yes 1 ∏Yes 2 ∏No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

A. ISEVORE

1. Date filed (Month, Day, NOV 2 1 2007

DHMH 17 Rev 1/2001

Hyattsville IND 20181

MD4203QUEENSLUPY Rel

32. Registrar's Signature

funeral director, after death.

| Director: /

this

ဥ

Certification:

Medical

State

\*Registrar

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

1 Inpatient

29c. License number

29d. Date signed (Month, Day, Year)

me and address of person who completed cause of death (it in 23a) (Type, Prime 3001 Hispital

Drive Cheverly Md 20785

31. Date filed (Month, Day, Year) NOV 2 1 2007

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Allen 12 Tyrone 1 2007 9.30p /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Richey Hospice USA Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 X M 2 □ F 12-29-59 212-82-4688 Md. 47 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No NA Md. **Funeral Director** Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21213 1906 N. Collington Avenue 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21√2 No Specify Be Completed by Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Tomke Aluminum Co. 12th grade Fork Lift Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) aryland Ellis Juanita Allen Louis ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 3914 Elmley Avenue, Baltimore, Md. Inetta Woods Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) = 0 Department of Important: If any Injury or once. 12-10-07 King Mem. Pk. Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility name and Address of Facility March F.H. East 11.01 E. North Ave., Baltimore, Md. 21202 lady 13 Warre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsenand Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a conseque Due to (or Examiner Sequentially list conditions, if cry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician the IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 3 Probably 2□ No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 25. Was case referred medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 DOther (Specify) Certification: To this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 1 Natural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certific

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Gladys Virginia Anderson December 4, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist. Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year March 16, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Months 1 □ M 2 🛛 F Mary land 91 214-24-1573 1916 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Florida | Palm Beach County Delray Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be n 902 South Drive 33445 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond L. Price Marv A. Urie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Keywood Court, Baltimore, MD Fletcher Reid Anderson 3rd/Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other pla Gardens of Faith 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12-8-2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Rd 10wson, MD 21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or comilications that caused the shock, or heart failure. List only one cause on each line. ealn. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COMPLICATIONS OF LEFT HIP FRALTURE WEEKS /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnapicy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by THACT INFECTION 1 Yes 2 No 3 Probably 4 Nonemark 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) HOSPICE 1 XYes 2 No ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 □ Natural 5 ☐ Pending investigation TRIP AND FALL OCTOBER 29, 2007 2.100 1 ☐ Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 0 30 OKTHORIDGE READ, WITHERWILE, MO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific DU4395 DECEMBER 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMERE, MD 21204 6565 N CHARLES ST, SUITE 209 VANIEUE DOBERHURN, MP

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	State of Man		artment of H		lental Hygier	T 0 0 1	39303
	Physici	an	1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Edna Ask 4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death	December	4, 2007 4c. County of Death	
	Examin	ler	42 Dalamar S-		. 1	Gaithe			Montg	omery
	Funeral Director		5. Social Security Number 6.  212-38-3159  Usual Residence of Decedent	Sex 7. Age (I	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yell November 19, 1	ar) Cou	place (State or Foreign intry) ryland
	yland		10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
	ours after death with the Manylan rel', or items 23a or 28a-f show Examiliar until be notified at	Funeral Director	Maryland Montgo	nery	Gaith	ersburg				1 Yes 2 No
	with the	Dire	10e. Street and Number 42 Dalamar St	reet Apt.	1	10f. Zip Code	877	10g.	Citizen of What Cor	_
	death ms 23	nera	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	ican Indian,
36	s after or ite	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 No	Specify:	rican, etc.)	Black, White	nite
00	72 hours "naturel",	ed p	3 Widowed 4 Divorced  15. Decedent's 8	Year or Dates:	16a. Dece	dent's Usual Occupa	ation	16b	Kind of Business/	77.
21215-0036	·= 48	Completed	(Specify only highest g Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	luring most of work )	ing	0 1	. /
	D D -		17. Father's Name (First, Middle, Las	<i>(</i> )		Cashier	18 Mother's Name	e (First, Middle, Maid	Reta	i <u>/                                     </u>
Maryland	e d tal	To Be	Jesse Harr	ison			Eve	lyn Bul	lock	
Mar	B is a 2	1 1	19a. Informant's Name/Relationship William Asbur		1 1			al Route Number, Cit		ip Code) 1D 20877
	s 1 and if Health item 27 other tr		20a. Method of Disposition			position (Name of matory or other place	or reel Al	Date 20c	Location - City or	own, State
mo	2 = 9 a		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Other (Spec	☐Removal from State ify)	Anatomy G	iffs Regis	try Decemb	er5,2007 H ztomy Gif	fanover, 1	10
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Liga	ansee	7	2. Name and Address 522 Conn	elley Dri	ztomy Gif ve suite P	tr Regist. Hanove	MD 21076
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	mplications that caused the y one cause on each line.						Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	PANCREA		CANCER				
	Examiner			Due to (or as a c	onsequence of):					
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence of):					
B	a be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
8760,	death certificata be executed e attending physician and ad for use as the burial-transit	ical E		d						
9	nificat ng phy as th	b	IF FEMALE:							
Вох	leath certifica attending pl	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
o.	that the de ned by the a detached f	ysic	in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	4☐ Pregnant at tim 9☐ Unknown	e of death 5 L	Other (specify)		-		
Ω.	es that igned b	by Pr	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w require been sig should b							1 Tes	2 □ No 3 Pro	bbably 4 Unknown
Vital Records,	elav has ye 2	Completed						24a. Was an autopsy performed	prior to death?	topsy findings available ompletion of cause of
tal		O	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2□ No ,
of Vi	Phyaiclan: this certific ral director,	To B	examiner? 1  Yes 2 No		2 ER/Outpatie		er: 4 🗍 Nursing Ho		6 □Other (Spec	ify)
o uc	ling After une	ion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time o lnjury	Work	rat <br Yes 2 □ No	28d. Describe how in	njury occurred	
Division	ie is at	ficat	2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Place of Injury	- At home, farm, st		163 2010	28f. Location (Street		ral Route Number,
Dİ	tel or is after el Dire	Certification;	4  Homicide determine	building, etc. (	Specify)			City or Town, Si	ate)	
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	edicai	29a. Certifier (Check only one) 1 Certifying P	hysicien: To the best of normalized manner: On the basis of example and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cause red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of dertifier			29c. License			Date signed (Month	
}			144	~ m	9		5635	De	CEMBER	05,2007
	1		30. Name and address of person who	completed cause of deat		Print)	OWE	y mo	2083	7
	Sta	1 31	31. Date filed (Month, Day, Year)	32. Registrar's	Signature			11		-
	Registr	ar	DEC 1 0	2001 Deceme	· S. A	234CL				

DHMH 17 Rev 1/2001

State

Registrar

2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39305 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year ROBERT 12:04PM JOSEPH DEC 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 XM 2 □ F 84 214-18-1258 01/28/1923 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3011 Belford Road 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. I □ Yes 2 X No f Yes, Give ∕ear or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Courier Columbia Association 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Blair Kathleen Corcoran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Maier-Thompson / Daughter 3011 Belford Road, Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Meadowridge Memorial Park 12/08/2007 Elkridge, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD M01378 Enter the disease, or defuncations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA 10 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Yea 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAILURE 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 2 🗆 No 1∐ Yes 2 **12** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 inpatient 2 ER/Outpatient 3□ DOA 27. Mann Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

**Physician** /Medical Examiner

Examine

Physician/Medical

2

Completed

Be

P

Certification:

Medical

29a. Certifier

(Check only one)

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or items 23a or 3 the Medical Examiner must be n

al Hygiene.

. Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 Is marked oth

Department of Health a Important: If Item 27 Is any Injury or other trau

with the

death

filed within 72 hours after

3altimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

ပ

burial-transit as the Se for page 2

P.O. Box 68760.

Division or Vital Records,

be execut attending physician ed by the a been signed by the should be detach has certificate this funeral After death. the filled in by

Hospital or Attending after death Director: 24 hours a within 2

State Registrar

2 Accident 6 ☐ Could not be determined 3 Suicide 4 ☐ Homicide

5 Pending investigation

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

WESTINSTER

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie

ATTENDING

D21155

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUDO 31. Date filed (Month, Day, Year) DEC 1 0 2007

and manner stated.

904 WASILUSTON BE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month Day Year brown 1030 AM DECEMBER 2007 Location of Death 4c. County of Death 8. Date of Birth (Month, Day, 07-17- Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Elkton 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number MOOGS . Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT as retired) Oo ege (1-4or 5+) Elementary/Secondary (0-12) ather's Name (First, Middle EIKton Wite . Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other ( 3 Removal from State 5 Other (Specify) of Funeral ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory re. List only one cause on each line. 23a. Part1. Enter the di-shock, or heart said Immediate Cause (Final disease or condition resulting in death) Acute Respire fory Due to (or as a consequence of): 430 wisch Piratrou 10 minih Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ibrillation 1 🗌 Yes 21 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner and

**Physician** 

/Medical

**Examiner** 

Director

Funeral

ð

Be Completed

**Funeral** 

Director

show r 28a-f show notified at

r than "natural", or items 23a or the M-dical Examiner must be

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than '

Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i

the burial-transit attending physician for use as the buria

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director.

Division or Vital Records, P.O. Box 68760,

Physician/Medical Completed Be Certification:

Examiner 1 Tyes 27. Manner of Death 1 Natural 2 🗌 Accident 3 Suicide 4 Thomicide

29a. Certifier

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Elleton 40

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 1 0

5 ☐ Pending investigation

6 Could not be

determined

29c. License number DO055/90

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) December 6, 2007

21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

und Union Harpital 106 BOW Street

32 Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State Registrar	State of Mar	yland		tment of H			giene Reg. No	007	39307
		Physic		Decedent's Name (First, Middle Daniel	e, Last) Raymond			lunt		2. Date of De Month Decemb	ath	2007°	3. Time of Death 10:25 PM
	4	/Medi Examii Funeral		4a. Facility Name (If not institution Gilchrist Cent 5. Social Security Number	<b>Eer</b> 6. Sex 7. Age		st birthday)	TOWSO If Under 1 Year		8. Date of Bir	4c. Cou	nty of Deat	h
		Director		218–16–9799 Usual Residence of Decedent	1 <b>X</b> M 2□F	81	Yrs.		110013	July 1	9,1926		ryland
		h the Marylan r 28a-f show r notified at	ctor	10a. State   10b. County   Maryland   Balt	imore	10c. City,	Town or Locat  Dunda						10d. Inside City Limits 1 ☐ Yes 2 X No
		th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 1212 Ridgeshire	Road			10f. Zip Code 2122	2		10g. Citizen		untry?
	9036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Mcdi-al Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S		s Decedent of I es, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	E	Race - Ame Black, White ecify. <b>Whi</b>	•
	Maryland 21215-0036	thin 72 ho e. an "natul M di al	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5+		16a. Deceden (Give kin life. DO	it's Usual Occu ad of work done NOT use retire	pation during most of work ed)	king	16b. Kind of		·
	d 21	filed wil Hygien rther th		7 years 17. Father's Name (First, Middle,	Last)		Turn	Forema	n 18. Mother's Nam	e (First, Middle	Bethle		Steel
	ylan	ould be Mental arked o	To Be	Joseph Vincent	Blunt				Hester E	thel Pr	ice Wi	llson	
		s 1 and 2 should be filed withir f Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M		19a. Informant's Name/Relations Jeffrey Blunt	hip (Type. Print)				t and Number or Ru nue <b>,</b> Dunda		-	wn, State, Z 21224	Zip Code)
25 pm	altimbre,	Pages 1 sent of He nt: If Item		20a. Method of Disposition  M☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Pla ce Oak	ace of Disposition Indumetery, cremate Lawn (	on (Name of tory or other pla <b>Cemeter</b>	Dece Y 10,		20c. Location	•	Town, State aryland
2	Baltii	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service		1	Coi	ame and Addre	Funeral H	ome Of	Dundall	k,P.A	750
•	1	Physician /Medical	3 1	23a. Part Lenter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused the only one cause on each line a.  Due to (or as a	rall	Do not enter t	the mode of dyi	ers Point ing, such as cardiac	or respiratory a	Dunda I. rrest,	k,Ma.	Approximate Interval Between Onset and Death
(e, 2007	8760,	icate be execute SX physician and SX multiple burial-transit sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to finite district cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Dine to (or as a Due to (or as a d.								
M M	.O. Box 6	he law requires that the death certific e has been signed by the attending p age 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pr 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal	death 3⊟Eo	ctopic pregnanc ther (specify) _	y		I	Date of deli Month	ivery Day Year
9 1	٥.	w requires that been signed by should be deta	d by Ph	Part II. Other significant conditi	ons contributing to death but	not resul	ting in the unde	erlying cause giv	ven in Part I.	23e. Did t			the cause of death?
	al Records,	D at a	Complete							24a. Was auto perfo 1 Yes	an 24 psy ormed? 2 1 No	lb. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of 2□ No
el Blunt	Division or Vital	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendir investing 1 Suicide 4 Homicide 6 Could determ	Hospital: 1 Inpatient  28a. Date of Injury (Month, Day)	Year)	28b. Time of Injury	28c. Inju Wo M 1	26. Place of Dealner: 4□ Nursing Houry at rk? 1 Yes 2□ No	ome 5 ☐ Resi 28d. Describe	dence 6 Xichow injury occ	curred	ural Route Number,
banie		le Hospital 124 hours a le Funeral I	Medical Ce	29a. Certifier (Check only one)  Certifyin  2 Medical	g Physician: To the best of Examiner: On the basis of e and manner state	xaminati	/ledge, death or on and/or inves	ccurred at the ti	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	I manner as ce, and due	stated. to the cause(s)
		To th  To th  comp	Me	29b. Signature and title of certifie				29c. Licens	se number 8 303		29d. Date sig		7 2007
-		8		11/1 0: -	HARIES IN	w	6701		rarles st	- DW	sen 1	up z	21204
	ì	Sta Regist		31. Date filed (Month, Day, Year)	32. Begistrar	_	- M	R)					
	DH	MH 17 Rev 1/2	001	sy t <sub>to</sub> , <b>∀</b> −36 − 0	Loo. Judge		ORIGI						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 39308 for State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:20P M DECEMBER 06, 2007 SHIRLEY ANN BYRD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 🐰 K F Yrs. NOV. 14, 1947 WASHINGTON, DC 60 579 64 2991 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Exercitual must be notified at XXYes 2 No Directo FORESTVILLE MD PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 5024 HILMAR DRIVE UNITED STATES natural', or Items 23a 20747 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes XX No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: BLACK þ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FEDERAL GOVERNMENT/ Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If Item 27 is marked other that any injury or other traumaric. INTERNAL REVENUE OFFICER IRS 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNETTE JOHNSON 0 PALMER JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9709 LAKE POINT COURT #202 UPPER MARLBORO, MD 20774 19a. Informant's Name/Relationship (Type, Print) DAUGHTER SABREENA A. JACKSON / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 12/11/2007 SUITLAND, MD 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND,
4308 SUITLAND ROAD SUITLAND, MD 20 SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** lon resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year jo Month Day signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 🗆 Yes 2 No 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Conpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Naturai 5 Pending investigation 1 □ Yes 2 □ No death. М 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours 🔝 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the th 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Wylonger. 30, Name and address of person who, completed cause of death (Item 23a) (Type 10 3001 Wander 31. Date filed (Month, Day, Year) State Registrar

	1 - For State Registrar	ate of Maryland	/ Department of Certificate or		, ,	ene 2. №2 N N 7	3930		
	negistrar     Decedent's Name (First, Middle, Last)		Och imodic of	Douth	2. Date of Death	No UU	3. Time of Death		
nn al	Douglas Mclearen Bra	agg			Decemb	er 6, 200	7 17:49		
er	4a. Facility Name (If not institution, give street		4b. City, Town,	or Location of Death	0000	4c. County of Dea			
	Sinai Hospita.	1 of Bulti	1 400	Homore		n/	a		
	5. Social Security Number 6. Sex 1 N M :	7. Age (In yrs. la. 2□ F 60	Months Dav		8. Date of Birth (Month, Day, ) December 3	<sup>(ear)</sup> 1946 Wa	rthplace (State or Forei ountry) Shington D		
	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location				10d. Inside City Limi		
ō		re County	Pikesvil	10			1 Yes 2 X		
Funeral Director	10e. Street and Number	e county	10f. Zip Code		100	g. Citizen of What C	ountry?		
	115 Church Lane		212	202		11C A			
ner	11. Marital Status 12. W	/as Decedent Ever in U.S.	. 13. Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No-				
by	1 Never Married 2 Married 1	☐ Yes 2☐ No Yes, Give ear or Dates:	1 ☐ Yes 2 ☐ <b>X</b> N		rican, etc.)	Black, Whi	White		
Completed	15. Decedent's Education (Specify only highest grade com	npleted)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	e during most of worki	ing 10	6b. Kind of Business	s/Industry		
E O	Elementary/Secondary (0-12) C	college (1-4or 5+)	Program Anal	•	9	ncial Sec	urity Adm.		
Be C	17. Father's Name (First, Middle, Last)		TI OGLUM MILL	18. Mother's Name			urrey Adm.		
70 B	Harry M. Bragg			Thelm	na Mae Sh	aw			
	19a. Informant's Name/Relationship (Type. P.	rint)	19b. Mailing Address (Street	et and Number or Rura	al Route Number,	City or Town, State,	Zip Code)		
	Diane L. Davisonn (At		1222 Glenback			Maryland			
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remove	val from State cer	ce of Disposition (Name of metery, crematory or other p	lace)		0c. Location - City or	r Town, State		
	4 □ Donation 5 □ Other (Specify)	Hillt	op Service Corpo		/2007   To	wson Maryl			
	21. Signature   Fur #AI Service Lio vise		22. Name and Add				21204		
-	23a. Part1. Enter the disease, or complication	Xv-		Funeral Home,			Approximate		
al Examiner									
3	d								
hysician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1   Vee 2   Vee 4	yes, outcome pf pregnand □Live birth 2 □ Fetal d □Pregnant at time of dea □Unknown	leath 3 Ectopic pregnar	су		23d. Date of de Month	elivery Day Year		
ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	□Live birth 2 □ Fetal o □Pregnant at time of dea □Unknown	death 3 □ Ectopic pregnar ath 5 □ Other (specify)		23e. Did toba	Month	Day Year to the cause of death?		
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9!  Part II. Other significant conditions contribut	□Live birth 2 □ Fetal o □Pregnant at time of dea □Unknown	death 3 □ Ectopic pregnar ath 5 □ Other (specify)		1 Dyes  24a. Was an autopsy performe	Month  cco use contribute t  2 No 3 P  24b. Were a prior to death?	Day Year of the cause of death? robably 4 Unkno		
Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions contribut  □ Yes 2 □ No 9 □ Unknown	□ Live birth 2 □ Fetal or □ Pregnant at time of dea □ Unknown	leath 3 □Ectopic pregnar sth 5 □ Other (specify) ing in the underlying cause g	iven in Part I.	1 Ves  24a. Was an autopsy performe 1 Yes 2[	Month  cco use contribute t  2 No 3 P  24b. Were a prior to death?  1 Yes	Day Year of the cause of death? robably 4 Unknorutopsy findings availa completion of cause of		
To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Live birth 2 □Fetal or □Pregnant at time of dee □Unknown  ting to death but not result	leath 3 □Ectopic pregnar sth 3 □ Other (specify) ing in the underlying cause grade	iven in Part I.  26. Place of Deathther: 4 □ Nursing Hol	1 □ Yes  24a. Was an autopsy performe 1□ Yes 2[  (Check only one) me 5□ Residen	Month  2 No 3 P  24b. Were a prior to death? 1 Yes	Day Year  of the cause of death?  robably 4 □Unkno  uutopsy findings availa completion of cause of		
To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Live birth 2 □Fetal or □Pregnant at time of dee □Unknown  ting to death but not result	leath 3 □ Ectopic pregnar 5 □ Other (specify)  ing in the underlying cause graph of the underly	26. Place of Death ther: 4□ Nursing Hor ury at ork?	24a. Was an autopsy performs	Month  2 No 3 P  24b. Were a prior to death? 1 Yes	Day Year  of the cause of death?  robably 4 □Unkno  uutopsy findings availa completion of cause of		
To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□ Live birth 2 □ Fetal of □ Pregnant at time of dea □ Unknown  Ling to death but not result ting ting ting ting ting ting ting tin	leath 3 □ Ectopic pregnar 5 □ Other (specify)  ing in the underlying cause graph of the underly	26. Place of Death ther: 4 \( \text{Nursing Hot} \) ury at \( \text{ork?} \)	24a. Was an autopsy perform 1 Yes 2 1 (Check only one) me 5 Residen 28d. Describe how	Month  2 No 3 P  24b. Were a prior to death? 1 Ye:  ce 6 Other (Sperinjury occurred	Day Year  of the cause of death?  Probably 4 □Unknow  uutopsy findings availal completion of cause of  s 2 □No		
Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□ Live birth 2 □ Fetal of □ Pregnant at time of dee □ Unknown  Ling to death but not result ting ting ting ting ting ting ting tin	leath 3 □ Ectopic pregnar 5 □ Other (specify)  ing in the underlying cause general state of the underlying	26. Place of Death ther: 4 \( \) Nursing Hor ury at ork? \( \) Yes 2 \( \) No	24a. Was an autopsy performent of the control of t	Month    Coco use contribute to	Day Year  To the cause of death?  Trobably 4 Unknow  Tutopsy findings availal completion of cause of a secify)  Bural Route Number,		
Certification: To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□ Live birth 2 □ Fetal of □ Pregnant at time of dea □ Unknown  Ling to death but not result ting ting ting ting ting ting ting tin	leath 3 □Ectopic pregnar sth 3 □ Other (specify)  ing in the underlying cause general states and states are states as a second states are states as a second state are states as a second sta	26. Place of Death ther:  4 \( \text{Nursing Hot ury at ork?} \)  Yes 2 \( \text{No} \)  9	24a. Was an autopsy perform 1 Yes 2[ a (Check only one) The State of City or Town, and due to the cau	Month    Coco use contribute to	Day Year  To the cause of death?  Trobably 4 Unknown  Trobably 4 Completion of cause of cause of the cause of the cause of the completion of cause of the cause o		
To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Live birth 2 □ Fetal o □ Pregnant at time of dea □ Unknown  ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting ting ting ting ting ting ting tin	aleath 3 □Ectopic pregnar 5 □ Other (specify)  Broutpatient 3 □ DOA □  Broutp	26. Place of Death ther:  4 \( \text{Nursing Hot ury at ork?} \)  Yes 2 \( \text{No} \)  9	24a. Was an autopsy perform 1 Yes 2 1 (Check only one) me 5 Residen 28d. Describe how 28f. Location (Stree City or Town, and due to the caued at the time, dat	Month    Coco use contribute to	Day Year  To the cause of death?  Trobably 4 Unknown  Tutopsy findings availal completion of cause of the cau		
Certification: To Be Completed by	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	□Live birth 2 □ Fetal o □ Pregnant at time of dea □ Unknown  ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death but not result ting to death ting ting ting ting ting ting ting ting	Beath 3   Ectopic pregnar ath 5   Other (specify)    Br/Outpatient 3   DOA   Other (specify)    Br/Outpatient 3	26. Place of Death ther:  4   Nursing Horury at ork?  Yes 2   No  e  time, date and place, or opinion, death occurrence number	24a. Was an autopsy performs 1 Yes 2 [a (Check only one) me 5 Residen 28d. Describe how 28f. Location (Stree City or Town, and due to the caued at the time, dat	Month    Coco use contribute to	Day Year  To the cause of death?  Trobably 4 □Unkno  Tutopsy findings availa  completion of cause of  s 2 □No  Tutopsy findings availa  completion of cause of  s s 2 □No  Tutopsy findings availa  completion of cause of  s s stated.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav 2007 06 /Medical 4c. County of Death Facility Name (If not institution, give street and numb Examiner 6 Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2KXF Min Hours Director 220-20-5948 78 JAN 25 1929 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1XIYes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death v 1959 W. LEXINGTON ST 2nd Flr. 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: BLACK þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade DOMESTIC PRIVATE permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other t any Injury or other traumatic event the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ WILLIAM GREEN VIOLA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Presbury/Cousin 2213 Cecil Ave., Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FALLSTON CEMETERY 12-12-07 FALLSTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. arvara Viloas 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one gluse on each line. Approximate Interval Between Ønset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the SBS attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown þ signed t Parall. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy certificate | performed Division or Vital 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2/1N 1 Hipatient 2 ER/Outpatient 3 DOA this 27. Manner - eath 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Matural Injury 1 ☐ Yes 2 □ No hours after death. I Director: / 2 Accident fo the. within 24 hou. م the Funeral Dire. اناد ثانا بات. 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) serson who complete Name and address Date filed (Month, Day, Year! gistrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cole Brannen	State of Maryland / Department of 1- For State Certificate of I		giene Reg. No. 201	07 3931
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		Date of Death     Month Day Year	3. Time of Death
ledical Examiner	Nicole Marie Brannen		December 5, 2007	1858 hrs
	4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Location of Death	4c. County of Deat  Dorchester	h
	Rt. 50 E/B @ 93 Mile Marker	Vienna		rthplace (State or
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	Forei	gn
Director	219-27-2393 1 M 2 X F 23 Yrs.		7/27/1984 °	ountry) Maryland
>	Usual Residence of Decedent  10a State 10b County 10c City, Town or Locatio			10d. Inside City Limits
w any		''		1 Yes 2 XNo
Aaryland 28a-f show 1 at once. ector	Maryland Baltimore Essex  10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?
the Maryland a or 28a-f sh tified at onc Director	tive. Street and Number			·
ith the same same same same same same same sam	1615 Williams Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21221  Decedent of Hispanic Origin? ( Sp	U. S. A. pecify Yes or No-	erican Indian, Black,
or items 23. must be no	1 X Never Married 2 Married Armed Forces?	s, specify Cuban, Mexican, Puerto		
ter de		Yes 2 X No specify:	Specify:	White
urs aftr tural" amitae	or Dates:	s Usual Occupation (Give kind of v		s/Industry
72 hours n "natu al Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use reti	rea)	1
Loo36 Lwithin 7 giene. her than her than	12 Hostes	SS	Restauran	t
21215-0036 Doubtld be filed within 72 hours after and Mental Hygies is marked other than "natural" reference over, the Medical Examine To Be Completed by	)   17.1. allies o turno (1. mar) maare, ====,		(First, Middle, Maiden Surname)	1
121: table fill ental larked arked yent,	Steven Brannen	Address (Street and Number of	Michele Pin Rural Route Number, City or Town, Sta	kard te Zip Code)
	-	Williams Avenue	Essex, Maryland	1
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic		tion (Name of cemetery,	Date 20c. Location - City	or Town, State
e Figure	1 Burial 2 X Cremation 3 Removal from State crematory or oth	1 14	2/10	Mawrland
Baltimore, permit. Pages 1 at Department of Her Important: If ite	4 Donation 5 Other Specify: Bayview C. 21. Signature of Funeral Service Licensee 22. N.			, Maryland
Baltimo permit. Page Department o Important: injury or ott	Br	ame and Address of Facility UZdzinski Funera 07. old Factorn 7	l Home PA <u>venue Essex, Mar</u>	vland 21221
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	e mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval
→ /M. dical	failure. List only one cause on each line.			Between Onset and Death
aminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
	Sequentially list conditions, b.			<del> </del>
inel	if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Cause			
Isit A ed	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
an and all - transit	d			
(0, e be execute ysician and burial - trar	UNPENDED			
76C icate icate g phys	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	al death 3 Ectopic pregn	23d. Date of deliverancy Month	ery Day Year
certif	past 12 months?    1	ner (Specify)		,
box 6876C.  The death certificate the death certificate to the attending physical and the box of th	1 Yes 2 No 9 V Unknown 9 Unknown			
P.O. E es that the d igned by the be detached		nderlying cause given in Part I.	23e. Did tobacco use contribute  1 Yes 2 ✔ No 3 P	
ords, P.O. w requires that as been signed by should be detail				
ords v requisional			autopsy prior t	autopsy findings available to completion of cause of
Records, The law requires freate has been sig. page 2 should be			performed? death 1 ✓ Yes 2 No 1 ✓	
tal Recolcian: The law certificate has ector, page 2 sl	25. Was case referred to medical	26.Place of Death (Check		
Vita hysici this c	Yes 2 No Inpatient 2 ER/Outpatient		ing Home 5 Residence 6 🗸 Ot	her: Scene
Division of Vital Records, P.O. Box 6876 tal or Attending Physician: The law requires that the death certificate at parted death. After this certificate has been signed by the attending phylicd in by the funeral director, page 2 should be detached for use as the bartification. To Re Commisted the Physician M.		njury 28c. Injury at Work?  1 Yes 2 ✔ No	28d. Describe how injury occurred Driver auto tractor trailer col	lision
sior trend death. ctor: y the i	Natural 5 Pending Dec 3, 2007		28f. Location (Street and Number or	Rural Route Number City
Division o spital or Attending tours after death. neral Director: After filled in by the fune	3 Suicide 6 Could not be determined (Specify) Highway	et, factory, office building, etc.	or Town, State) Rt. 50 E/B @ 93 Mile Marker, Vi	
Divis Hospital or A 24 hours after Funeral Dire stely filled in b	4 Homicide determined (Specify) Highway  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	ared at the time, date and place, an		
Divi  To the Hospital or within 24 hours after To the Funeral Dir completely filled in	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	tion, in my opinion, death occurred	at the time, date and place, and due to	the cause(s)
To the within. To the comple	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (	
	Dt. Was - Pallacin	O.C.M.E.	December 6, 2	2007
,/	30. Name and address of person who completed cause of death (Item 23a)			
5	Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimo	ore, MD 21201	
Stat	te 31. Date filed (Month, Day, Year) DEC 1 0 2007	rade		
Registra	DEC 1 0 2007 persone to by	A=00#4		

	for State Registrar		State of IV	iaryiano		tificate of		Mental Hygi	ene <sub>3. No.</sub> 2 (	007	3931
ın	Decedent's Name (First)							Date of Death     Month	Day	Year	3. Time of Death
al	Francin							11	30	07	0970 M
r	4a. Facility Name (If not in		. / /	. /	100		r Location of Deal	th		ty of Death	2
H	5. Social Security Number	<b>PG/ON/M</b> 6. Sex		ge (In yrs. Ia	TH ast hirthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	N	OMIC	blace (State or Foreig
	156-28-7066	1 [	M 2₹F	68	Yrs.	Months Days	Hours Min.			Cour	ntry)  Jersey
	Usual Residence of Deced	dent County		10c. City	, Town or Lo	cation					10d. Inside City Limits
5	1.60	omerset				s Anne					1 ☐ Yes 2√ No
Lec	10e. Street and Number					10f. Zip Code		100	g. Citizen of	f What Cour	ntry?
runeral Director	P.O. Box 75	4					21853		III	SA	
<u> </u>	11. Marital Status		12. Was Decedent Armed Forces		3. 13.	Vas Decedent of F		Specify Yes or No- to Rican, etc.)	14. Ra	ace - Americ ack, White,	
2	1 □ Never Married 2[ 3 💢 Widowed 4 □ Di		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			I ☐ Yes 2∏ No	Specify:	to riloan, etc.)		ify: whi	
erec	15. De (Specify only	ecedent's Educ y highest grade	cation e completed)	- 1	16a. Deced	lent's Usual Occup	ation during most of wo	orkina I	6b. Kind of I	Business/In	dustry
Completed	Elementary/Secondary (		College (1-4or	5+)		kind of work done OO NOT use retire	d)				
	17 Esther's Name (First #	Middle Leet)	0		<u>c1</u>	erk	10 Matheda Na	ann (First Middle Ad		ery s	tore
2	17. Father's Name (First, Manager Self)							me (First, Middle, Ma	alden Surna	ame)	
2	19a. Informant's Name/Re		ne Print)		10h Maii-	a Address /Ctra-+		ie Kazak	City on T	n C+-+- 7	- Code)
	Jennie Amec		,					ural Route Number,	-		J Code)
	20a. Method of Disposition		STOLEI	20b. Pl	ace of Dispo	ongwood L sition (Name of natory or other place	rive Gro	oveville,		<u>620</u> ı - City or To	own, State
	1 ☐ Burial 2 ☐ Crem 4 ☐ Donation 5 📉 Q	ther (Specify)	in state	;			i 6 9			-	
	21. Signature of Euneral S RONA	Service License	hade, Dir	ector	St	Name and Addre	ss of Facility Omy Boar	d 655 W.	Baltin	nore S	Street
edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sountially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Year? Years	
ed											
r II ysiciati/w	IF FEMALE:  23b. Was decedent pregnating the past 12 months  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	anı	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3□	Ectopic pregnanc Other (specify)	/			ate of delive	ery Day Ye <i>a</i> r
L y	Part II. Other significant c	conditions con	tributing to death I	out not resul	ting in the ur	derlying cause giv	en in Part I.	23e. Did toba	cco use coi	ntribute to th	he cause of death?
	Hypert	the sten						1 ☐ Yes	2∐ No	3 Prob	oably 4 □Unknown
completed	N 7/21/14	pident	غز					24a. Was an autopsy performe		prior to co death?	opsy findings available impletion of cause of
3	25. Was case referred to n	medical					26 Place of Da		No	1 🗆 Yes	2□No
	examiner? 1  Yes 2 No	<u> </u>	lospital: 1 ☐ Inpati	ent 2∏F	R/Outpatien	3DE DOA Oth	er.	ath <i>(Check only one)</i> Home 5 ☐ Residen		ther /Specif	f <sub>(</sub> )
	27. Manner of Death	100	28a. Date of Inj	ury	28b. Time of	28c. Injur		28d. Describe how			y/
	2 Accident	Pending investigation	(Month, Da	ay rear)	Injury		K? Yes 2 □ No				
		Could not be determined		jury - At hor tc. (Specify)		eet, factory, office		28f. Location (Stre City or Town,	et and Num State)	nber or Rura	al Route Number,
	29a. Certifier 114 Co (Check only one) 2 M	ertifying Phys edical Examír	siclan: To the best ner: On the basis of and manner st	of examinati	rledge, death on and/or inv	occurred at the til restigation, in my o	me, date and place	e, and due to the cau urred at the time, dat	se(s) and ne and place	nanner as s e, and due to	stated. o the cause(s)
	29b. Signature and title of	certifier	2 (	7		29c. Licens				ed (Month,	*
-	30 Name and address of p	person who co	/	leath (Item	23a) (Type, I	Print)	106 Mile	7 Salve	1	-/1	008 (
9	31. Date filed (Month, Day,	Year)	32. Begist	rar's Signati	ILIMIN ure	we Heart	Smiti le	15 Palis	bury 1	1021	804
r	DEC	1 0 20		m h	* A	edi					

2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Kavontay\_Branch DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sinai HOSPITA Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Yrs. Nov. 30, 2007 Director Usual Residence of Decedent 10c. City, Town or Location Baltimore Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21213 2727 Chesterfield Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2**∑** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🍇 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Derrick Branch, Sr. Lola Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Lola Branch / Mother 2727 Chesterfield Avenue; Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory 12/07/2007 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, 21. Signature of Funeral Service Licens 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Ulmonary /Medical Due to (or as a consequence of): Examiner EmbolU5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation

2 No 3 Probably 4 Nunknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

Month

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1√DYes 2 No

25 minutes

25 minu+65

2007

4c. County of Death

USA

14. Race - American Indian,

Black, White, etc

African American

29a. Certifier

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygien [ ]

6 ☐ Could not be

0042821

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

2401 W. BELVEDETE AVE. Baltimore, md

State Registrar

Medical

DEC 1 0



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

To the Hospital or Attendl within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per the 874 12-12-07 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) r 6,2007 Physician 12:30P.M December Milton Brown Richard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sept13,1940 Maryland Months Days 1 MM 2□ F 67 216-38-3822 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 No Director White Marsh Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21162-1609 U.S.A. 5827 Loreley Beach Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed ♣☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Baltimore City 911 Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Siebert Edward F. Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Scott Step-Son
Scoot Gagnon (grands 4427 Carlyn Road Perry Hall, Md. 21128 <del>coot</del> Gagnon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Chremation 3 ☐ Removal from State Bayview Crematory 12-8-2007Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service License 1201 Dundalk Ave. Baltimore, Md. 21222 Sod 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC WOUNDS Months **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit KHEUMATOLP Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Division or Vital Records, P.O. 9 Unknown Atter this certificate has been signed by the funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Dio 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2.55No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☐No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28c. Injury at Work? or Attending Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DECEMBER 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST. 8MTE 209 BALTMORE, MD 21204 DANIEUE DOBERMANIMO 31. Date filed (Month, Day, Year) 32. gistrar's Signature

DHMH 17 Rev 1/2001

Registrar

DEC1 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

anend item 31 per day 9874 12-10-07 yr
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** Elizabeth Frances Bond 11:45 AM 12 2007 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore GOOD SAMARITAN HUSPITAL N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 7F 093-30-0040 71 11-21-1936 Director New York Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Tx Yes 2 □ No ns 23a or 28a-f sl must be notified Director Md N/A Baltimore 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 6009 Marluth Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Rauscher Lucille Totten 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Bond-Husband 6009 Marluth Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/12/07 Baltimore, Maryland Gardens of Faith 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Flyneral Service Licensee 6415 Belair Road Baltimore, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Immediate Cause (Final Physician Due to (or s a consequence of): disease or condition resulting in death) /Medical Examiner piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical avansed 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Inknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fen som 1 Yes 2 No 3 Probably 4 Unknown a beter 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 1 No Caronery 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Hospital: မ 1 Dipatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year) 07 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samaritan 6000 32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	of Maryland / Depa	artment of Health and M rtificate of Death	Mental Hygie		39316
- 4	Physic	ian	Decedent's Name (First, Middle, Last)     MARY C. BERTCH			2. Date of Death Month	Day Yeer	3. Time of Death
100	/Medi Examir			f number)	4b. City, Town, or Location of Death		4c. County of Dea	6:27 P M
#	_Adi/iii		4a. Facility Name 41 got institution give street and HAMMONDS LANE CENTER	2	BROOKLYN PARK		ANNE A	
10-12	Funeral Director		5. Social Security Number 216-03-1957 6. Sex	F 88 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye AUG. 30,	9. Bir 1919	thplace (State or Foreign buntry) MD •
	/iand		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Ba-fsh	Director	MD. ANNE ARUNDI	EL BROOKLY	YN PARK			1 □ Yes 2X No
	with th	Dire	10e. Street and Number 613 HAMMONDS LANE		10f. Zip Code	1	Citizen of What Co	ountry?
	death me 23	Funeral	11. Marital Status 12. Was I	Decedent Ever in U.S. 13.1	21225 Was Decedent of Hispanic Origin? (Sp		SA 14. Race - Ame	erican Indian.
Maryland 21215-0036	172 hours after death with the Maryland "natural", or Iteme 23a or 28a-f show idical Exeminating the motified at	by	If Yes	es 2 ZNNo	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
15-0	"nai	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business	Industry
212	l within 72 iene. r then "nai	ошо	Elementary/Secondary (0-12) College 12TH	je (1-4or 5+)	CCE ADMINISTRATOR		REAL ESTA	ΔTE
pu	I S H	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		ALE.
yla		To	JOSEPH WERNER			E ZIEMAN		
, Mar	P = F =		19a. Informant's Name/Relationship (Type, Print) DIANE HARMAN/DAUGHTER	409 N	g Address (Street and Number or Rur IELROSE AVE., GLE	al Route Number, Cit	ty or Town, State, 2 MARYLANI	Zip Code) D 21225
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 【Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	METRO CR	LEMATORY 12/0	4/2007 <sub>BA</sub>		MARYLAND
Balt	permit. Depart Import any inj		21. Signature of Foreral Service Ligensee		Name and Address of Facility CH 224 EASTERN AVE.,			
20			shock, or neart failure. List only one cause	on each line.	er the mode of dying, such as cardiac			Approximate Interval Between
	Physician /Medical		resulting in death)		REAST CANCE	n		Onset and Death  2 1EALS
1	Examiner			to (or as a consequence of);				
	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of).				
Ö,	icate be executed physician and sthe burial-transit	Exa	enactions in density to as	to (or as a consequence of):				
8760,	cate b physic the b	dical	d					<u> </u>
.O. Box 6	ath certif titending for use a	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of del	ivery Day Year
σ,	uires that the de signed by the a d be detached t	by Ph	Part II. Other significant conditions contributing t	o death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	w requires been sig should be	ed b				1 ☐ Yes	2 <b>X</b> No 3 □ Pr	obably 4 Unknown
Records,	The law rate has be page 2 sho	Completed				24a. Was an autopsy performed	? prior to death?	topsy findings available completion of cause of
Vital	ysician: Th	Bec	25. Was case referred to medical examiner?		26. Place of Death	1 Yes 2 1	10 105	2 0 100
	this at dia	٠ <u>.</u>		☐ Inpatient 2 ☐ ER/Outpatient te of Injury 28b. Time of		me 5 Residence		erfy)
0	nding P ath. r: After e funera	ation	1 Natural 5 Pending (Maccident investigation	te of Injury 28b. Time of Injury Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Division of	p et in	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, stre alding, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the Funeral Director of the Funeral Director	edical Co	Concentration of the	e dasis of examination and/or inv	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause ed at the time, date a	o(s) and manner as	stated. to the cause(s)
:	To the To the comple	Mec	and it	anner stated.	29c. License number	29d. [	Date signed (Monti	n, Dey, Year)
)			1 / Sin Cin,	llan mo	131/36		11/29/2	7
	V		30. Name and address of person who completed o	ause of death (Item 23a) (Type, F	29c. License number D31/36 Print) KICBRIDE AD	4.4	u -	,
**	Sta	e	BRIAN C. WALLA 31. Date filed (Month, Day, Year) 32	KB, WD 9005 . Registrar's Signature	KIUDRIBE KO	DARTIN	none m	0 21236
	Registra		DEC 1 0 2007	Recon K de	act 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 0830 AM Angelina 07 2007 Marie Collins December /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner FRANKLIN Square HospiTAL Center Rosedale Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 □ M 2√2 F Director 214-16-8224 85 Jan. 9,1922 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 200No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Aldworth Road 21222 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced White permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturany Injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturing 6 Years Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John Baucia Ann Mazzucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Drescher (Grandson) 608 Aldworth Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_5 ☐ Other (Specify) Gardens of Faith Cem. 12/11/2007 Baltimore, Maryland 21. Signature of Kneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0515 /Medical Due to (or as | consequence of): **Examiner** neumonia Sequentially list conditions, if arry, learning to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed betes and/ Due to (or as a consequence of) burial physician Box 68760, Physician/Medical the SE IF FEMALE 23c. If ves, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 4☐Pregnant at time of death P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No page certificate or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral Di

completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-07-07

State Registrar 30. Name and address of person

FLIN

NG

Square

DR

Baltimore

MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

9000 FRANKLIN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	artment of Health and Me <i>rtificate of Death</i>	ental Hygier Reg. 1	0007 00010						
	Physici	on.	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death						
÷	Physici /Medic	cal	Naomi B. Carter	4b. City, Town, or Location of Death		007 Year 10:19a .m.						
	Examir	ier	4a. Facility Name (If not institution, give street and number)  11612 Clocktower Lane	Laurel		Prince George's						
	Funeral Director		5. Social Security Number  212-28-5683  6. Sex 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea 2 IO 2	9 Birthplace (State or Foreign						
	yland now at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ecation		10d. inside City Limits						
	ne Mar 8a-f st Stiffed	Director	MD Prince George Laurel			1 □ Yes XXNo						
	ath with the 23a or 2 ust be no	ral Dire	10e. Street and Number 11612 Clocktower Lane	10f. Zip Code 20708		Citizen of What Country? USA						
980	a within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	1 Nover Married 2 Married 1 Vec 2 No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes  2 No  Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black						
5-0	72 hc "natur	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry						
2121	filed within Hygiene. rther than " ent, the Mes	Completed	12th N/A Lor	ndon Town Manufacto	ry	Examiner						
Maryland 21215-0036	be d of eve	To Be	17. Father's Name (First, Middle, Last)  Donald Boyce	18. Mother's Name (	(First, Middle, Maid elmina	en Surname) Griffith						
Mary	d2: thai			ng Address (Street and Number or Rural 2 Clocktower Lane								
Baltimore,			IKOSUNAI 2 LICTEMATION 3 LIHEMOVAI ITOM State I	position (Name of matory or other place)  Memorial Park 12/1		Location - City or Town, State  Baltimore Co. MD						
Baltin	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility MARC 101 E. North Avenue	CH FUNERA	L HOME-EAST						
Г	k		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death						
	Physician /Medical		immediate cause (Final disease or condition resulting in death)									
	Examiner		Due to (or as a consequence of);									
7	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
0	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):	Necetic								
68760,		edical	d									
Вох	death certi e attending d for use a	Physician/Me		□Ectopic pregnancy □Other (specify)		23d. Date of delivery Month Day Year						
s, P.O.	s that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?						
ord	w require been sig should b	ted k			1 Tyes	2 No 3 Probably 4 Unknown						
Division or Vital Records,	2 38 a	Completed			24a. Was an autopsy performed 1 Yes 201							
Ž.	ysician: The scentificate director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death  Other: 4 Nursing Home		6 ☐Other (Specify)						
n 0	ng Phys fter this ineral di		27. Manyrer of Death  Natural 5 Pending  28a. Date of Injury (Month, Day Year)  (Month, Day Year)  28b. Time of Injury		Bd. Describe how in							
/isio	l or Attending I after death. Director: After in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determine	M 1 ☐ Yes 2 ☐ No	Pf Location (Street	and Number or Rural Route Number,						
Ö	ital or irs after ral Dire		Dullding, etc. (Specify)		City of Town, Sta	ate)						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, deatt check only one)  1 ☐ Certifying Physician: To the basis of examination and/or in and manner stated.	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)						
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)						
)	in		Meal NI)	1235118		2-10-07						
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, KASH ( PASH ) 3(DD W YMAH)	PARK DRIVE	BALTI	WEE MA 21211						
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 0 2007 Registrar's Signature	who will								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2007 beatnee 7:45 AM storgeana DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINA HOSPITAL OF BALTIMORE N/A RALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) **Funeral** P Yrs. Hours Months Days 1 ☐ M 2 👿 F 220. 36. ld 89 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Baltimore 1 ☐ Yes 2 No Milk **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I Coule Road Apt. # 405 2111 4700 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 21215-0036 1 ☐ Yes 2 XNo Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Baltimore County 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pacher Public Schools 12th grade lot Years aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Pages 1 and 2 should be Mable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Cobb 20a. Method of Disposition /Sov Bee Court Ellicott City MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetry 12/12/2007 Woodlawn, MD 4 Donation 5 Dother (Specify) 22. Name and Address Facility Vaupan C. Greene Funeral Services 21. Signature of Funeral Service License Vaugha C. Road Randallstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE Physician KINAL 6 MONTHS /Medical Due to (or as a consequence of): Examiner HYPERTENSION Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 N No 24a. Was an perform 2 **2** No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number RES 000 PECEMBER S, 2007

State

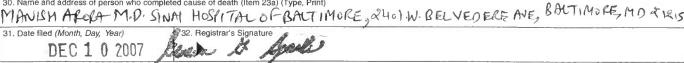
Registrar

C

31. Date filed (Month, Day, Year)

DEC 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year BARBARA LOUISE CONNALLY 11:35P M 29, NOVEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORESTVILLE NURSING AND REHAB FORESTVILLE PRINCE GEORGES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M XX F Director 464 62 1658 SEP. 04, 1930 OKLAHOMA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits XXYes 2 □ No Director MD PRINCE GEORGES DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6205 ELMHURST STREET 20747 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes **2CX**No Specify. þ Specify: BLACK 3 Widowed XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry FEDERAL GOVERNMENT/ Elementary/Secondary (0-12) College (1-4or 5+) 12TH PROGRAM SPECIALIST DEPT. OF NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLYDE HICKERSON EMMA DAVIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALMAH BANDY / SISTER 6205 ELMHURST ST. DISTRICT HEIGHTS, MD 20747 20a. Method of Disposition

XZBurial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 12/07/2007 BRENTWOOD, MD 21. Signature of Fyneral Service License 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MARYLAND, 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part , Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examine attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes XX No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ XX Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed: 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital; Other:XXX Nursing Home 5 Residence 6 Other (Specify) 1 Yes XX No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51520 DECEMBER 07, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 SOUTHERN AVE. SE WASHINGTON, DC 20032 BAHRAM PISHDAD, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Please	State of Ma			Ensure All C lealth and Men			39321			
			For State Registrar	Otate of Ma		rtificate of	Death	Reg	g. No.				
	Physici /Medic	_	1. Decedent's Name (First, Middle, L Marguerite A.	Clas			P.	Date of Death Month Cember	Day Year	3. Time of Death 1:15p M			
	Examin		4a. Facility Name (If not institution, g 6828 White Rock			4b. City, Town, o Sykesvil	r Location of Death $1 \mathrm{e}$		4c. County of Dea	ath			
	Funeral Director		218-52-1965	Sex 7. Age 1 M 2 X 94	(In yrs. last birthday, Yrs.	Months Days	Hours Min. (	Pate of Birth Month, Day, ril 6	9. Bi 1913	rthplace (State or Foreign ountry)  MD			
	Maryland I-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County Carrol1		10c. City, Town or L Sykesv		· · · ·			10d. Inside City Limits 1 □ Yes 2 🎇 No			
	with the	Il Direc	10e. Street and Number 6828 White Rock	Road		10f. Zip Code 21784			g. Citizen of What C USA	ountry?			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ⅓ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 X N If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	lispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Am Black, Wh Specify:				
21215-0036	within 72 ho ene. than "natur te Medical	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5-	(Give	_	eation during most of working d) rm business		6b. Kind of Busines: agricultu	,			
Maryland 2	uid be filed withir Mental Hygiene. rked other than tic event, the Ms	To Be Co	17. Father's Name ( <i>First, Middle, La</i> William Keene	st)	Paza		18. Mother's Name (Fir Helena So	st, Middle, M	aiden Surname)				
Mary	and 2 should be fi ealth and Mental H n 27 Is marked otl her traumatic ever		19a. Informant's Name/Relationship Robert Clas (son		I		and Number or Rural Rock Rd., Syke		•				
nore,	Pages 1 and 2 nent of Health ant: If Item 27 I ury or other tra		20a. Method of Disposition 1 ☐ Burial 2 <b>X</b> Cremation 3			ematory or other plac	Date 12-14-0	i	Oc. Location - City o				
Baltimore,	permit. P. Departme Important any Injury once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic	ensee	2	22. Name and Addre	ss of Facility Haight	Fune	ral Home	·			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Malianath  Melanana										
1	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a	conseque of):								
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):									
68760,	ate be executed hysician and the bunal-transit	<u>a</u>	resulting in death) Last	Due to (or as a	a consequence of):								
P.O. Box 6	Physician: The law requires that the death certificate is this certificate has been signed by the attending physical director, page 2 should be detached for use as the trail	Physician/Medic	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i>	у		23d. Date of d Month	elivery Day Year			
	quires that in signed by uld be deta	5	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba 1 □ Yes		to the cause of death? Probably 4 □Unknown			
or Vital Records,	: The law requir cate has been si page 2 should	Completed						24a. Was an autopsy perform 1□ Yes 2	/ prior to				
Vita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 □ ER/Outpatie	ent 3 DOA Oth	26. Place of Death (Ch	_		necify)			
on or	ding Phy n. After this funeral c	00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							ome 5 Residence 6 □Other (Specify)  28d. Describe how injury occurred				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	he desired	ry - At home, farm, s (Specify)		28f.	Location (Str. City or Town,		Rural Route Number,			
	le Hospita 1.24 hours le Funera	Medical C		Physician: To the best of taminer: On the basis of and manner sta	examination and/or ited.	nvestigation, in my	opinion, death occurred a	t the time, da	ite and place, and d	ue to the cause(s)			
	To the within To the comp	Me	29b. Signature and title of certifier  • MMM & M	>		29c. Licens	se number 3681 14 Elders	29	d. Date signed (M)	nth, Day, Year)			
	10		30. Name and address of person wi	1380 Pro	eath (Item 23a) (Type Gress Way	Print) Suite	14 Elders	burgi	MD 21	784			
* 7	Sta Regist		31. Date filed (Month, Day, Year) DEC 1 0	2007 32. Registra	ir's Signature	grante							

Registrar DHMH 17 Rev 1/2001

			1 - For State of Maryla		artment of		d Mental Hy	giene Reg. No	2007	39322
	Physici		1. Decedent's Name (First, Middle, Last) Mary Ethel Colliflower				2. Date of De Month Decemb	eath		3. Time of Death 11:55a M
I	/Medio Examir		4a. Facility Name (If not institution, give street and number) 7426 Village Road		4b. City, Town, Sykesv	or Location of D		4c.	County of Death	h
	Funeral Director		5. Social Security Number 216-14-6186 6. Sex 1 □ M 2 M F 92 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Yea Months Day		in. Jan 4	1915	9. Birth Cou	place (State or Foreign intry) MD
	Maryland	tor	Usual Residence of Decedent   10a. State   10b. County   10c. C	ity, Town or Lo Sykesvi						10d. Inside City Limits 1 X Yes 2 □ No
	3a or 28	I Direc	10e. Street and Number 7426 Village Road		10f. Zip Code 2178	4		10g. Citiz USA	zen of What Cou	intry?
36	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is marked other then "neturel", or Iteme 23e or 28e-f show styl injury or other treumatic event, the Medical Exaction main be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Ammed Forces?  1 Yes 2 No If Yes, Give A Year or Dates:		Was Decedent of I Yes, specify Cu		(Specify Yes or No uerto Rican, etc.)		14. Race - Amer Black, White Specify: wh	
21215-0036	within 72 hounds one. Then "neture then "neture"	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occ kind of work don DO NOT use retii	upation e during most of ed)	working		nd of Business/li	ndustry
and 2	lbe filed value Hygie od other levent, In	Be	12 17. Father's Name (First, Middle, Last) Oscar Miller	0101			Name (First, Middle	e, Maiden :	Sumame)	
Maryland	id 2 should th and Me 27 is mark treumatic	10	19a. Informant's Name/Relationship (Type, Print) Shirley Snyder (daughter)		-	and Number o	Rural Route Numb			p Code)
altimore,	Peges 1 end nent of Health ant: If Item 27 ury or other ti		20a. Method of Disposition 2 Democrat from State 20b.	cemetery, cren 1 Count	sition (Name of matory or other p	tion 12-		Ŝyke	cation - City or Testion - Cit	MD
Balt	Depertre Imports eny inju		21. Signature of Funeral Service Licensee  Tauge Saught Service				laight Fur esville, l			Chapel
	death certificate be executed by Scician and Wedical Example of the set of th	icai Examiner	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consection of the cause).  Due to (or as a consection of the cause).	quence of):			diac or respiratory a			Approximate Interval Between Onset and Death
. Box	death certific e ettending p od for use as i	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fellows 1 □ Pregnant at time of 9 □ Unknown	tal death 3	Dectopic pregnar	су		2	23d. Date of delik	very Day Year
۵.	uires thet the de signed by the e Id be detached f	Completed by Ph	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause (	jiven in Part I.		tobacco u		the cause of death?
Records, P.O. Box 68760,	The law requires thet the ate has been signed by the pege 2 should be detache								24b. Were aut prior to c death? 1 \( \sum Yes	topsy findings available ompletion of cause of
	Physiclan: Th rthis certiticate ral director, peg	Be	25. Was case referred to medical examiner?	7.50.0		ther	Death (Check only			
on of	ding Phys h. After this funeral di	lon: To	27. Manner of Death 1 ZNatural 5 Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. in	4 🗀 11411511	28d. Describe		S ☐Other (Spec y occurred	ity)
Division	or Attendition distribution of Attended Incorporation of the Incorporati	Certification:	2 Accident 3 Suicide 4 Homicide  investigation 6 Could not be determined  28e. Place of Injury - At building, etc. (Special Could not be determined)	nome, farm, str				(Street and own, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier (Check only one) 1 Gertifying Physician: To the best of my kr	iowledge, death lation and/or in	h occurred at the vestigation, in my	time, date and p opinion, death (	lace, and due to the occurred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier		29c. Lice	2080 G		29d. Date	e signed (Month	, Uay, Year)
	b Sta	ate_	30. Name and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of person who completed cause of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and address of death (literature) and death	102/	Print) (	BORTY	RD E	ZDOR	SBURG 1	MD 2178
DH	Regist	rar	DEC 1 0 2007	1. 1	rock					

Division or Vital Records, P.O. Box 68760, €.

		_ For	State	of Maryland	-				nd Me	ntal Hy	giene		
					Cei	Certificate of Death				Reg. No.			39323
Physic	ian	Decedent's Name (First, Middle	, ,							Date of De Month	Day	Year	3. Time of Death
/Medi	cal	Raman1a1	Jagjivan		i	4h Cih	T	l acation of F		ecembe		2007 ounty of Dea	6:45 A M
Examir	ner	4a. Facility Name (If not institution	-	,	ital			Location of D	Death			ounty of Dea ontgom	
Funeral		Montgomery Con 5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under		If Under 24		. Date of Birl	h	9. Bir	thplace (State or Foreign
Director		212-11-1921	1 <b>∑</b> M 2□ F	88	Yrs.	Months	Days	Hours	Min. N	ov 20			ountry) India
pu .		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside City Limits
naryle Fshored at	ō			100.01,									1 □Yes 2X No
the N 28a-i notifi	Director	Maryland   Montgo	omery		-	Gaith 10f. Zip		urg			10a. Citize	n of What Co	ountry?
3a or		8103 Shady Spr	ing Drive				208	77		ļ			•
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene.  Ither than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status		edent Ever in U.S	. 13.	Was Dece		spanic Origin n, Mexican, F	n? (Specif	y Yes or No			erican Indian,
after or ite		1 ☐ Never Married 2 ☐ Marr		2√ No ive No		il Tes, spe 1 □ Yes		Specify:	ruello nil	Jan, etc.)		Black, Whi	te, etc.
ural";	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates:								A	sian-Indian
in 72 in mat in mat	Completed	15. Decedent (Specify only highes	st grade completed)		16a. Deced (Give life, L	kind of wo DO NOT us	ai Occupa rk done di se retired)	ation <i>luring m</i> ost of )	of working		16b. Kind	of Business	/Industry
withingiene.	E O	Elementary/Secondary (0-12)	College (	(1-4or 5+)		ccoun					I	Accoun	ting
e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)					18. Mother's	s Name (F	First, Middle,			
uld bu	ToE	Jagjvandas H	arjivan	Sagar				Mani	iben	Chol	kshi		
2 sho and l is ma		19a. Informant's Name/Relationsl	hip (Type. Print)		19b. Mailir	ng Address	(Street a	and Number o	or Rural F	Route Numbe	er, City or T	own, State,	Zip Code)
and Health		Mukesh R. Choxi	/son					ing Dr					aryland20877
tiges 1 If life or of		20a. Method of Disposition 1 ☐ Burial 2 XCremation		State	ace of Dispo metery, crer				Date			ition - City or	
it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (S <sub>1</sub> 21. Signature of Funeral Service		West				tory 1					Maryland
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical Once.		21. Signature of Funeral Service	2 Thoma	5	De 1	onald 411 A	son . .son .	s of Facility Funera olis R	al Ho Road	me & ( Odent	Cremat	tory, Maryla	P.A. nd 21113
		23a. Part1 Enter the disease, or shock for heart failure. List	complications that only one cause on	caused the death. each line.	Do not ent	er the mod	le of dying	g, such as ca	ardiac or r	espiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_a. 4+1	12vosc14	protic	Ca	rdio	vascu	elar	Dise	ase		Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conseque	ence of):								
	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseque	ence of);			-					
uted uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,								
be executed sician and burial-transit		resulting in death) Last	Due to	(or as a conseque	ence of):								
cate be e	dical												
	Med	IF FEMALE:											
sician: The law requires that the death certificate certificate has been signed by the attending physector, page 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	tcome pf pregnan birth 2  Fetal	death 3□	Ectopic pr					230	d. Date of de Month	livery Day Year
the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□Unkn	nant at time of dea	atn 5∟	Other (sp	ecity)						
that I		Part II. Other significant condition	ons contributing to d	leath but not result	ting in the ur	nderlying c	ause give	n in Part !.		23e. Did to	bacco use	contribute to	o the cause of death?
quires n sigr ald be	d by	Congestive 1	Heart F	ailure						1 🗆 \	′es 2□	No 3□P	robably 4 Unknown
aw re	Completed	1								24a. Was	an	24b. Were a	utopsy findings available completion of cause of
The I	m o				45						rmed? 2 No		
stan: ertifice ctor, p	Be C	25. Was case referred to medical examiner?						26. Place of	f Death (C	1□ Yes Check only o		1 □ Yes	2 110
hysic this or	ပ္	1 Yes 2 No			R/Outpatien			4 LI Nursii	ing Home	5 ☐ Resid	lence 6 [	□Other (Spe	ecify)
iing F After funera	ion:	27. Manner of Death 1 Natural 5 Pending	9 '	of Injury oth, Day Year)	28b. Time of Injury		8c. Injury Work			d. Describe h	iow injury c	occurred	
death death ctor: y the	icat	2 Accident investig 3 Suicide 6 Could n	ot be	e of injury - At hon	ne. farm. stre	M eet, factor		′es 2□No		Location (Street and Number or Rural Route Number,			
after after I Dire	Certification:	4 ☐ Homicide determi	build	e of injury - At hon ling, etc. <i>(Specify)</i>	, , , ,	, ,	,		201	City or Tou	n, State)	vai.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ara riodte ramoci,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director;		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the	e best of my know	ledge, death	occurred	at the time	ne, date and p	place, and	d due to the	cause(s) ar	nd manner a	s stated.
the H in 24 the Fi	Medical	one)	Examiner: On the band man								date and p	race, and du	e to the cause(s)
Nett To	2	29b. Signature and title of certifier	1 11. 11.	11		290	: License	number	0				th, Day, Year)
/		Mulle	halfe fu	//		15	002	872	7		Decen	nber:	3,2007
12		30. Name and address of person Phyllis Wicholson	who completed caus	se of death (Item 2)	23a) (Type, I	Print)	Inou	Mar	ulan	1			
Sta	te	31. Date filed (Month, Day, Year)	3 <b>/</b> 2 F	Registrar's Signatu	ire A			1	jun	ч			
Registr	ar	DEC 1 0	2007	se of death (Item Prince Phi)	Alpa	acre .							
			at "					_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

31. Date filed (Month, State Registrar

29b. Signature and title of certifier

Worth Charles St, Soite 209, Pouson MD 21204 ck 6565 2. Registrar's Signature Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

00061199

29d. Date signed (Month, Day, Year)

		For State Registrar	Ple	ase Type o State			d / Depa	artment of I	Health	and N				le.	0.01	
	n	Registrar  1. Decedent's Nam	ne (First, Midd	tle, Last)			Cei	rtificate of	Deatr	7	2. Date of D	Reg. No	20(	17	3 9 ( 3. Time of	3 2 5 Death
Physici /Medio		Ch	eryl	F	rand	cis	D	avis			Month DECEP	Da 1BER		ear	11:44	РМ
Examir		SIMAL	Hos	on, give street and r		ALTIM	TORE	4b. City, Town, BALTIM	ORE	CI			: County of NA			
Funeral Director		5. Social Security N 213-70-	1349	6. Sex 1 ☐ M 2 🔀 F	7. Ag	e (In yrs. la 50	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of B (Month, E	irth Da <i>y, Y</i> ea <i>r,</i> L—195	57	9. Birthpl Count	ace (State or ry) Md	_
rland ow at		Usual Residence o 10a. State	10b. Count	y		10c. City	, Town or Lo	cation						10	d. Inside Cit	ty Limits
e Mary a-f sh tifled	ctor	Md.		NA		1	Baltim	ore							1 XYes	2□No
th with the 23a or 28 ist be no	al Dire	10e. Street and Nu 3122 V		a Avenue		-		10f. Zip Code 212	:15				tizen of Wh JSA	at Count	ry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed		rried 1 TYes	Forces? 3 2 🔀 I Give			Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No			pecify Yes or No Rican, etc.)	lo-	14. Race - Black, Specify:	America White, e	tc.	
72 hc 'natur dical	eted	(Spe	15. Decede	nt's Education est grade completed	1)		(Give	dent's Usual Occu kind of work done	during mo	st of wor	king	16b. K	ind of Busin	ness/Ind	ustry	
ed within ygiene. <b>ner than</b> ' it, <b>the Me</b>	Completed	Elementary/Second 12th gr	ondary (0-12) ade	College NA		5+)	life. I	no NOT use retire abled	ed)				JA			
d be fill ntal H ed oth	Be	17. Father's Name Irvin	(First, Middle		ohns	son					e (First, Middl stine	e, Maider	,	mpso	n	
id 2 should Ith and Me 27 is mark fraumatio	To	19a. Informant's N Angela J		ship (Type. Print)	ter	-	19b. Mailir 487	ng Address (Street Windeme	t and Numb	ber or Ru	ral Route Num	ber, City o	or Town, St		Code)	
is 1 and of Health Item 27 other tr	-	20a. Method of Dis	position			20b. Pla	ace of Dispo	sition (Name of matory or other pla	200)		Date	20c. L	ocation - Ci	ty or Tov	vn, State	
Pages nent of ant: If It ury or o		1 Burial 2 4 Donation		3 □Removal from Specify)	n State		rinity		!	12-1	2-07	Dι	undalk	c, Mo	ā.	
permit. Departi Importa any inj once,		21. Signature of Fe	uneral Service	Licensee	A			2. Name and Addre			March 1					
PD = 60		23a Parti Enter I	the disease	C. Wall	U	A)		101 E. N					∍, Md.		L202	
Physician /Medical		sho'k, or hea Immediate Cause disease or condition r-sulling in death)	(Final	a.	I		eed.	er the mode of dy	ing, such a	s cardiac	orrespiratory	arrest,		,	Approximate Interval Betw Onset and D	veen leath
be examined cian and ourial-transit	al Examiner	Sequentially list co if any, leading to in cause. E. its Tunde Cause (Disease or that initiated events resulting in death)	injury S	C	o (or as	a conseque	ence of):	OF	Liv	ER					3 JEA	RS
ficate be physicials the bu	dica			d					·					+		
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? □ No		birth gnant at	pf pregnar 2  Fetal time of de	death 3	Ectopic pregnand Other (specify)	ey				23d. Date o		•	'ear
res that igned by be deta	by Ph	Part II. Other signi	ficant condit				Iting in the ur	nderlying cause giv	ven in Part	I.	23e. Did	tobacco	use contribu	ute to the	cause of de	eath?
w require been sig should b	led k	CART	DIAC	HRR	<u> 2                                   </u>	T					1/2	Yes 2	□ No 3	☐ Proba	bly 4 □U	nknown
stcian: The law r certificate has be rector, page 2 sh	Completed										24a. Was auto peri 1⊡ Yes	opsy formed2	prio dea	re autop or to com ath? ]Yes 2	sy findings a pletion of ca	vailable use of
lcian: certific ector,	Be	25. Was case refer examiner?		Hospital:				Tou		e of Deat	h (Check only	_				
this all di	2	1 Yes 22		28a. Dat			R/Outpatien 28b. Time of	1 3 DOA		ursing Ho	ome 5 Res			(Specify)		
Attending Physician: r death. ector: After this certifica by the funeral director, p	tion	1 □ Natural 2 □ Accident	5 🗌 Pendi	/8.6	onth, Day		Injury	Wo	rk? Yes 2	No	Zou. Describe	now inju	ry occurred			
al or Atte s after des il Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ∏ Could deterr	nined   200. Plat	ce of injuding, etc	ury - At hon c. (Specify)	me, farm, stre	eet, factory, office			28f. Location City or To	(Street ar own, State	nd Number	or Rural	Route Numb	эө <i>г</i> ,
To the Hospital or Attend within 24 hours after death. To the Funeral Director: , completely filled in by the f	edical C	29a. Certifier (Check only one)	Certifyi 2☐ Medica	ng Physician: To the Examiner: On the and ma	ne best of basis of unner sta	i examinati	/ledge, death on and/or inv	n occurred at the tivestigation, in my	ime, date a opinion, de	nd place	and due to the red at the time	e cause(s e, date an	) and mann d place, and	er as sta d due to	ited. the cause(s)	
To the Complex complex	M	29b. Signature and			a D	BS		29c. Licens		100			te signed (/		. ,	
\			mingdo					RE						ER	7,200	>7
H		50 Name and addr	4 4 A	who completed ca	use of de	eath (Item :	23a) (Type, 1	Print) BELV	EDER	ε t	BALTIM	ORE	na	0 2	1215	)
Sta Registra		31. Date filed (Mon	EC 1 0	2007	Hegistra	ars Signatu	The Page	de la								

			For State Registrar	State of M	larylar	-			ealth a Death	and M		giene, Reg. No.	200	7	39326
	Dhuaisi		1. Decedent's Name (First, Middle, La	~ .							2. Date of De Month	ath Day	Yea	ır	3. Time of Death
4	Physici /Medi		LLOYD	DAR	IEN	)					12	05	305	_	11:GEP M
1	Examir	er	4a. Facility Name (If not institution, giv		-	5 1 0in	4b. City,	Town, or	Location o			4c.	County of D		
			VA BREC 396  5. Social Security Number 6.5	o Loch		last birthday)	If Under	ALI 1 Year	If Under:		8. Date of Bir	*b	10	/ A	ann (State of Samina
	Funeral Director			127 M 2 □ E	58	Yrs.	Months	Days	Hours	Min.	8 25	y, Year)	9. 1	Count	ace (State or Foreign ry) MD
			Usual Residence of Decedent							1					
	arylar show		10a. State 10b. County			ty, Town or Lo								10	od. Inside City Limits  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	the Marylar 28a-f ehow notified at	cto	MD N/A			Baltimo									
	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f ehow littel Extendrer must be multified at	Funeral Director	10e. Street and Number 633 N. Aisquith	St Ant	18#		10f. Zip	212	202			10g. Citiz	en of What	Count	ry?
	eath	era	11. Marital Status	12. Was Deceden		IS. 13 V	Was Decer			nin? (Spe	cify Yes or No		4. Race - A	merica	n Indian
10	r Iten	F.	1 X Never Married 2 Married	Armed Forces 1 17 Yes 2 If Yes, Give	?					, Puerto I	cify Yes or No Rican, etc.)		Black, W		
5-0036	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 No	Specify:				Specify:	В	ack
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gra	ducation (de completed)	-	16a. Deced	dent's Usua kind of wo	al Occupa	ation furing most	t of workii	ng	16b. Kir	nd of Busine	ss/ind	ustry
2121	within ene. then "	ig II	Elementary/Secondary (0-12)	College (1-4or	5+)				)			,	7.73		
2	filed v Hygie ither t		12th 17. Father's Name (First, Middle, Last	N/A		Die	able	d	18 Mothe	r's Name	(First, Middle		N/A Sumame)		
Maryland	ould be Mental I Marked o	o Be	Claude Darier						Rut		(First, Mission		Colber	t.	
2	shoul nd Me mari	ျှ	19a. Informant's Name/Relationship (			19b. Mailir	ng Address	(Street a			i Route Numb				Code)
	alth a		Ruth Darien-mothe	er		633 N	I. Ais	squit	th St	reet	Apt. 1	8H B	altimo	ore	, MD 21202
J.	of He of He Item		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Nar	ne of	e)	D	ate	20c. Lo	cation - City	or To	vn, State
Ĕ	Page nent ant: II		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Ga	rrison	Fore	st V	A :	12/14	4/2007	Owi	ngs Mi	13.3.8	s MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mantal Hygiene. Importants if Item 27 is marked other then "naturel", or Iteme 23a or 28a-1 ehow amy followy or other traumatic event, the Madical Examiner must be notified at any follow.		21. Signature of Funeral Service Licer	1500		-				-	CH FUNE				
-	90 E 4 9		Mlad	of W	ane						ue Balt		e, MD	-	21202
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.						r respiratory a	rrest,			Approximate Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pan	cre	atic	(	irci	inar	nd					
	/Medical Examiner		1	Due to (or a	s a consec	quence of):									
	¥	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consec	juence of):									
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.											
oʻ	e exection and an arrial-tu	Exe	resulting in death) Last	Due to (or a	s a consec	ruence ol):	-								
8760,	law requires that the death certificate be executed as been signed by the attending physician and so should be detached for use as the burial-transit.	Physician/Medical	•	d											
9	that the death certific. ed by the attending pl detached for use as t	/Mec	IF FEMALE:	02- 11	4									1	
Вох	sath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. Il yes, outcom 1 Live birth 4 Pregnant	2 Feta	ıl death 3 □	Ectopic pr					2	3d. Date of a Month		y Day Year
P.O.	the de	ysic	1 Yes 2 No	9□ Unknown	at time of t	Health 5	J Other (sp	жеспу)							
	that ned by deta	by Pr	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the ur	nderlying c	ause give	n in Part I.		23e. Did t	obacco u	se contribute	to the	e cause of death?
rds	w requires that s been signed b should be deta	d be									10	Yes 2	No 3□	Proba	ably 4 □Unknown
ဝွ	awre is bec	piet									24a. Was		24b. Were	autop	sy findings available
Ĕ	The law ete has page 2:	Completed									autor perfo	ormed? 2 No	death	1?	pletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
£	Physician: this certifice ral director, I	은	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat		ER/Outpatien			4 Nu	rsing Hon	ne 5 Resi	dence 6	Other (S	ресіІу	)
n o	ding P	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		28c. Injury Work			28d. Describe	how injury	occurred		
isi	Attending in death. sctor: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not b		- At h		M		Yes 2 1		101 Location /	Ctroot a no	d Alumbas as	Dura	Pouts Mumber
Division of Vital Records,	I or Attendi efter death Dirsctor: A I in by the fu	Certification:	4 Homicide determined	28e. Place of Ir building, e	itc. (Specia	ome, farm, str	eet, ractory	у, опісе		1	281. Location (. City or To	wn, State)	7 NUMBER OF	nurar	Route Number,
	spita nours neral	a C	29a. Certifier Certifying Ph	ysician: To the bes	t of my kno	wledge, death	occurred	at the tim	ie, date and	d place, a	and due to the	cause(s)	and manner	as sta	ated.
	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Medical Exar	niner: On the basis and manner s	of examina	ation and/or inv	vestigation	, in my of	oinion, deat	th occurre	ed at the time,	date and	place, and o	due to	the cause(s)
_	To the within To the comp	M	29b. Signature and title of certifier	0 .			290	C. License	number			29d. Date	signed (Mo	onth, E	Day, Year)
	. \		Lund.	Kolocs	00	NO		15	ひりょ	54		12	JUOF	05	
	241		30. Name and address of person who	completed cause of	eath (Iter	п 23а) (Туре.						60	CH P	AV	EN BUID
	0-		LEON N. F	MLACPI	trar's Signa	M.D.	J	BAL	J.M.	OCE	, MD	21	318		
	Sta Registr	_	31. Date filed (Month, Day, Year) DEC 1 0 20	07 Hegis	irai s signa	Appl	We !								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Per Phy G874 12/10/07/intrate of Death

Reg. No. Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ам Ida Elizabeth Dunaway 12/04/2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 116 South Ann Street Baltimore N/A If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Director 407/22/7792 04/20/1922 KY 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 South Ann Street 21231 USA Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Homemaker 8 Own Home traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any lininy or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roger Fisher Jessie Leibee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila A. Moore / Neice 116 South Ann Street, Baltimore, MD 21231 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Derivation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mamorial Park | 12/07/2007 Elkridge, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 232 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, physician a Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes P.O. been signed by the should be detached 9☐Unknown 9 Unknow significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 20 No Hospital: 1 ☐ Inpatient 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred al or Attending F after death. After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) manner stated 29b. Signature and the 29d. Date signed (Month, Day, Year)

State Registrar

Registrar DEC 1 0 2007

Date filed (Month, Day,

leted cause of death (Item 23a) (Type, Print

egistrar's Signature

· Leink

000

CHOI

Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 26 5:30 PM Eira Reese Dorn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9508 Night Song Lane Columbia Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 15, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Pennsylvania Director 214-44-7426 93 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9508 Night Song Lane 21046 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William David Reese Winifred Thomas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy D. Kalin 9508 Night Song Lane, Columbia, Maryland 21046 Daughter 20b. Place of Disposition (Name of cometery, crematory or other place Crestlawn Memorial 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 11-30-2007 4 □ Donation 5 □ Other (Specify) Marriottsville, MD Gardens 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part1. Enter the diseas shock, or heart failur. or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, transport of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of: Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed ves 2 No death? 1 ☐ Yes certificate 2□ No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Many of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route-Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. To the mosphine after death.

To the Funeral Director: After this of the Funeral Director after this of the funeral director. the Hospital

29b. Signature and title of certifier

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1120 N. Rolling RD Baldo MD 21268

State Registrar

10

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) DEC 1 0 2007





tel certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Oate of Death December 8, 2007 Physician. Dylewski 4:25 A M Esther M. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex Riverview Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. January 3, 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Maryland 83 Director 217-14-9474 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic svent, the Madical Examinar roust by notified at 1 X Yes 2 □ No Director Baltimore Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21224 37 North Decker Avenue Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify White 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home **HOusewife** 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hyant: If item 27 Is marked oth Elizabeth Holowinski Peter OLszewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37 North Decker Avenue, Baltimore, Maryland 21224 Daughter Marlene Del Brocco 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Baltimore City, MD. Bayview Crematory 11,2007 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lite Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Un-Immediate Cause (Final Physician Advance a disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Live birth 2 Fetal death jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ~ weis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has funeral director, page 2 autopsy performed? 2 1 NO 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 212 No 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Diractor: A
filled in by the fu investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Thomicide within 24 hours 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-08-2007 NED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN BLUD, M.D-2/22) 709. PASBAM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760 2

		1 - State Registrar			Cei	rtificate of L	Death		F	leg. No2 () (	7	39330_
		1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea	th Day	Year	3. Time of Death
Physicia /Medic		Louise	H. Decke	r					Decemb	er 7, 20	07	11:35р м
Examin		4a. Facility Name (If not institution Gilchrist	on, give street and nu	mber)		4b. City, Town, or TOWSON	1			4c. County o	of Death timo	re
uneral irector		5. Social Security Number 215–18–7338	6. Sex 1 ☐ M 2 🔼 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Birtl FeD • 2	9 <sup>Year</sup> 1912	9. Birthp Coun Mar	lace (State or Foreign
>		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	, Town or Lo	cation					1	0d. Inside City Limits
Ba-f sho	Director	Md. Balt	imore	W	hite H							1 □Yes 2 XNo
23a or 2 ust be no	al Dire	10e. Street and Number 2614 Garrett	Road			10f. Zip Code 21161				10g. Citizen of W	USA	
or items	y Funeral	11. Marital Status  1 Never Married 2 Mar	rried Armed Formed 1 ☐ Yes If Yes, Gi	2 🔀 No ive		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🏿 No			ecify Yes or No- Rican, etc.)	Black	- Americ k, White, Whi	
tural", ai Exe	d by	3 ☑ Widowed 4 ☐ Divorced		Dates:	16a Dece	dent's Usual Occup	ation			16b. Kind of Bu	siness/Inc	dustry
than "nat he Medica	Completed	(Specify only higher Elementary/Secondary (0-12)		1-4or 5+) +4	(Give	kind of work done on DO NOT use retired	during mos	st of worki	ing	Nursin		,
Department or neating and wenter riggerer.  Important: If them 27 is marked orther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	æ	17. Father's Name (First, Middle William A.	, Last) Hall				18. Mothe		e (First, Middle,	Maiden Surnam	e)	
Traumati	မှ	19a. Informant's Name/Relation Mr. Robert Deck		2.00		ng Address (Street a						Code)
Item 2 other		20a. Method of Disposition		_	lace of Dispo emetery, cre	osition (Name of matory or other place	ce)	E	Date	20c. Location -	•	
tant: #		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🗶 Other (	Specify)Entomb	ment Dru		dge Cemet	5		.1-07	Pikesv	ille.	, Md.
import any in		21. Signature of Fund al Service	1. TX	5	2:	2. Name and Addres RUCK TO 1050 YO	ss of Facility WSON rk Rd	Fune	eral Homowson, M	la: 2120	4	
ysician		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition	or complications that st only one cause on	caused the deatleach line.	n. Do not en	ter the mode of dyin	ig, such as $Acc$	s cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
Medical aminer		resulting in death)	Due to	(or as a conseq	uence of):							V-Y-3.
d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(or as a conseq	uence of):							
sician an burial-tr		resulting in death) Last	Due to	(or as a conseq	uence of):							_
g phy as th	Medical											
wrinn 24 nours arter dearn.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 □ Yes 2 ☑ No 9 □ Unknown	1□Live	utcome pf pregna birth 2 □ Feta gnant at time of d nown	Ideath 3	□Ectopic pregnancy □ Other (specify)	/			23d. Dat Mo		ery Day Year
ed by		Part II. Other significant condi	tions contributing to	death but not res	ulting in the u	inderlying cause giv	en in Part I	I.	23e. Did t	obacco use conti	ribute to t	he cause of death?
en signe uld be	ed by	Dementiq							10	Yes 2□No	3 ☐ Pro	bably 4 Dunknown
e has bee age 2 sho	Completed					Add to the second secon			24a. Was auto perto	osy rmed?	orior to co death?	opsy findings available impletion of cause of
tificat tor, pa		25. Was case referred to medic	al				26. Place	e of Deat	th (Check only o		☐Yes	2 DA40
direc	ro Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	er: 4□Ni	ursing Ho	ome 5 Resi	dence 6 🗟 Oth	er <i>(Sp</i> eci	tv) Hospice
atn. r: After th ie funeral	ation: T	27. Manner of Death 1 Natural 5 ☐ Pend 2 ☐ Accident inves	(8/10)	e of Injury nth, Day Year)	28b. Time of Injury	Wor	ryat k? Yes 2 □	]No	28d. Describe	now injury occurr	ed	
s arter des al Directo ad in by th	Certification	3 Suicide 6 Could 4 Homicide deter	minod 206. Flat	e of injury - At ho ding, etc. <i>(Specii</i>	ome, farm, st	reet, factory, office		_	28f. Location ( City or To		er or Run	al Route Number,
n 24 hour ne Funera sletely fille	Medical C	29a. Certifier 1 Certify (Check only 2 Medical	ring Physician: To the al Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, dea ation and/or i	th occurred at the tinvestigation, in my	me, date a opinion, de	and place	, and due to the rred at the time,	cause(s) and ma date and place,	anner as s	stated. to the cause(s)
To th	M	29b. Signature and title of certif	/	ð		29c. Licens		ç		Dec. F.		-
2		30. Name and address of perso	on who completed cau	use of death (Iter	1/1	1. 6-	Suite	200	7, 7005	on line	) 2	1204
Sta		31. Date filed (Month, Day, Yea	0 2007	Peristrar's Signa	ature							
Regist		DLUI	0 4007	Halin	S A	200152						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 200<sup>7</sup>7 **Physician** JOSEPH December 6, 11:18 a<sup>M</sup> **JAMES** DARRAH, JR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y July 13, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Social Security Number . 1923 Days Hours 1∏M 2□ F Yrs Pennsylvania 183-12-0721 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Txt Xes 2 □ No Laurel Directo Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 U.S.A. 7700 Cherry Lane, Apt. 118 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ¥∑Yes 2 □ No If Yes, Give Year or Dates: WW 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ X 1000 Specify: þ White 3\NWidowed 4 □ Divorced WWII Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Grade 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Crane James J. Darrah, Sr. 19a. Informant's Name/Relationship (Type. Print) 19h Mailing Address (Street and Number or Bural Boute Number, City or Town, State, Zio Code) 11511 Basswood Court Laurel, Maryland daughter Alda Simpson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawnview Cemetery 12/10/2007 Rockledge, PA 21. Signature of Funeral Service 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Erter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Possible Heart Attack Due to (or as a consequence of): Acute Renal Failure Sequentially list conditions, it any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Pneumonia Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4√3Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2XXNo 24a. Was an autopsy perform 2XXNc 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes **₹X**No 1 X X patient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760. attending properties for use as signed to

this

After

To the within 2.

10

**Funeral** 

Director

28a-f show

iral", or Items 23a or 28a-f sh Examiner must be notified

the Maryland

death with

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural any Injury or other traumatic and ponce.

Examine Physician/Medical þ Completed certificate has b irector, page 2 s director, Be ို funeral Certification: Director: / within 24 hours aft To the Funeral Di completely filled in Medical

27. Manner of Death 2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier

(Check only one)

29b. Signature and jill

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

[X Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 64874

29d. Date signed (Month, Day, Year) December 6, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 Little Patuxent Parkway, Suite 200, Columbia, MD 21044 Shahab Z. Bavani, MD

State Registrar

2. Registrar's Signature 2007

and manner stated.

CK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year Physician Emae 28 2007 2:00p Katina 11 Christina /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 6670 Snowberry Ct. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ₽ F 219-86-6536 35 Director 9-18-1972 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County 28a-f show ns 23a or 28a-f show must be notified at 1X Yes 2 □ No Md. NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be nonce. USA 21214 6670 Snowberry Ct. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Team Leader Target 12th grade 17. Father's Name (First, Middle, Last) l yr. 18. Mother's Name (First, Middle, Maiden Surname) Be Emge, Jr. Beatrice Gerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 Alconbury Rd., Essex, Md. Maria Williams Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12-6-07 Randallstown, Md. King Mem Pk 21. Signature of Funeral Service Lice 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Tes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greisma 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 39333 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mary Elizabeth 2007 11:45 AM Espey December 6, /Medical 4a. Facility Name (If not institution, give street and number)

Ivy Hall Geriatric Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Middle River If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 214–12–2564 7. Age (In yrs. last birthday) 86 yrs. 8. Date of Birth (Month, Day, Year) 11/15/1921 6 Sex **Funeral** Months Days Hours 1 M 280AF Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. Count 10a. State 27 is marked other than "natural; or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 TYes 2 No Baltimore Essex Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code with U.S.A. 21221 1049 Foxchase Lane death v Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married Specify: White 1 ☐ Yes ŽŽNo Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Queen Anne County Elementary/Secondary (0-12) Cotlege (1-4or 5+) Assistant Zoning Administrator Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clara Fry Phillip Potter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traum once. 1049 Foxchase Lane, Essex, Maryland 21221 John Espey, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 12/10/2007 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death tmmediate Cause (Final angrowe 2-3 mothy **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 2 NO 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA his 28a. Date of trijury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.
Funeral Director: After the letely filled in by the funeral Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of trijury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12-08-2007 N-P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N MD-2/221 BASTERN NASERM 709. MALIKA 31. Date filed (Month, Day, Year) 32 Pegistrar's Signature State DEC 1 0 2007 Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 03 4/3 PM William J. Ernstberger Sr 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 10, 1915 8. Birthplace (Sta Country) Maryland Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1**∑** M 2□ F Director 92 215-01-3725 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1620 Colesbury Place 20794 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mechanic automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Ernstberger Louise Holt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ernstberger Jr/son 1620 Colesbury Place Jessup, MD20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Director State Anatomy Board Baltimore, MD 21201 Ronald 3 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or as a consequence of) Anorexia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Be

that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760, physician the as attending asn ō ģ has page 2 certificate Hospital or Attending Physician: after death Director: /

**Funeral** 

28a-f show

with 1

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at

is marked other than

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it

**Physician** 

/Medical

Examiner

Certification: To To the Hospital o within 24 hours aft To the Funeral Di completely filled in

		performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	26. Place of Death (	Check only one)
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home	e 5 Residence 6 Other (Specify)
27. Manner of Death  1	n (Month, Day Year) Injury Work?  M 1 Yes 2 No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 1 Certifying Pl	hysician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the course(s) and manner as stated

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nancy Rivera-King 1209A , M.D. Marda Lane, Annapolis, MD 21403

and manner stated.

State Registrar 31. Date filed (Month, Day, Year) DEC 1 0 2007

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

attending physician ed by the a has certificate To the Funeral Director; After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed or Attending Physician: Hospital

within 24 hours a To the Funeral I To the

State Registrar

and manner stated. 29b. Signature and title of certifier

29c. License number D44969 29d. Date signed (Month, Day, Year) December 5,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Kravet, M.D. 4940 Eastern Avenue Baltimore, Md.

31. Date filed (Month, Day, Year)

			For State	State of Mar	yland /		artment of H rtificate of L		•	giene Reg. No <i>!</i>	0007	20236
			Registrar  1. Decedent's Name (First, Middle, Last	t)			timodio or E		2. Date of De	ath	2001	3 9 3 3 6 3. Time of Death
	Physicia		Curtis	100			Erit-	2	Month	Day	Year 2007	7:55 PM
	/Medic Examin	-	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	Dec		County of Deat	
	LAAIIIII	٠.	Shady Grove Adven	tist Hospit	al		Rockvil1	le		M	lontgome	ery
e de Gra	Funeral		Social Security Number     6. Se		In yrs. last	birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Vear	9. Birt	hplace (State or Foreign untry)
	Director		514-12-3593	X M 2□F	8.	3 Yrs.	Months Days	Hours Min.	Nov. 4	, 192	4 Kar	isas
	pu ,		Usual Residence of Decedent	14	On City T		ti-n					40d Inside City Limits
	aryta show d at	-	10a. State 10b. County		0c. Cify, T							10d, Inside City Limits 1 ☐ Yes 2X No
	Ba-f	Director	Maryland Montgome	ry	Gai	thers	sburg		1			
	vith th		10e. Street and Number				10f. Zip Code	2		_	zen of What Co	-
	s 23s	Funeral	18913 Glendower R	12. Was Decedent Eve	ar in II C	12.1	20879		onify Von or No		ed Stat	
	ter de Item	5	11. Marital Status  1 ☐ Never Married 2 ◯ Married	Armed Forces?			Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White	
5-0036	hours after death with the Maryland Jural", or Items 23a or 28a-f show al Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	1 ★Yes 2 No If Yes, Give 1 Year or Dates:	944 <u>-</u> 1949		1 ☐ Yes 2 ☑ No	Specify:			Specify: Whi	te
ž	72 hou 'natura dical E		15. Decedent's Edu	ucation	1 1	6a. Dece	dent's Usual Occupa	ation		16b. Kir	nd of Business/	industry
נוב	hin 7 an "n Medi	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	-	life.	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work )	ang			
7	filed within Hygiene. other than "	Ö		5+	I	nform	nation Sys	tems Spec	ialist	For	eign Se	rvice
2	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Nam			Surname)	
<u>Xa</u>	2 should be and Mental Is marked o aumatic eve	၉	Lorence H. Fritz					Mattie R				
Maryland	and ls m		19a. Informant's Name/Relationship (7)		1		ng Address (Street a					
2 ~	and lealth m 27		Shirley Fritz / W	ife			Glendowe					
0	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Menth Hygene. It of Health and Menth Hygene. If item 27 is marked to ther than "natural", or items 23a or 28a-f show If item 27 is marked the the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □	Removal from State	cem	etery, crei	osition (Name of matory or other plac thaven	Dec.	Date 6,		cation - City or	
	t. Pa tmen tant: dury		4 □ Donation 5 □ Other (Specify		Men	oria	l Gardens	20				Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signature of Funeral Service Licens	see		Ré	Name and Address I	Funeral S	ervices	, Sk	kot Cod	ly P.A.
			23a. Part1. Enter the disease, or comp	lications that caused th	e death. [		501 Catoct				ick, ML	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.		. 1		1		,		interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aA+ Due to (or as a c	Urn	ria/	nemo	rchage				(day
	Examiner	i		11,000	vton	(in		/				/
	2.4	Jer	Sequentially list conditions, if any, leading to immediate	Due to or as a c	onsequen	ce of):						
Û	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.								
Š	an ar an ar irial-t		resulting in death) Last	Due to (or as a c	onsequen	ce of):						
08/90	ificate be executed physician and st the burial-transit	edical	•	d								
_		Med	IF FEMALE:									
X Q Q	death cert e attendin d for use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2	☐ Fetal de	ath 3□	Ectopic pregnancy			2	23d. Date of dei Month	livery Day Year
- -		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of deat	n 5L	Other (specify)					,
7.	requires that the een signed by th		Part II. Other significant conditions of	ontributing to death but	not resultin	a in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
Ġ.	signe d be	l by		3			, 0		10	Yes 2	No 3⊟Pr	robably 4 □Unknown
ö	v requ	etec							24a. Was		Odb Wore o	stones findings espilable
Vital Records,	rsician: The law s certificate has b lirector, page 2 sh	Completed							auto		prior to death?	topsy findings available completion of cause of
ā	n; T fficate or, pa		25. Was case referred to medical					OC Plana of Daniel	1 Yes	2 No	1 ☐ Yes	2□ No
>	Physician; this certific ral director,	o Be	examiner?	Hospital: 1 ☐ inpatient	2 N EB	/Outnatier	ot 3 DOA Othe	26. Place of Deat er: 4 ☐ Nursing He			COthor (Coo	aif d
ō	g Physer this eral dii	-	27. Manner of Death	28a. Date of Injury	28	b. Time o			28d. Describe			City)
VISION	al or Attending F s after death. Il Director: After d in by the funera	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day Y	rear)	Injury		Yes 2 □ No				
<u>                                      </u>	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.	- At home	, farm, str	reet, factory, office		28f. Location ( City or To			ural Route Number,
5	tal or safte	Certification:		Danaing, oto.					ON, 01 10	,, Olalo,		
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Exam	ysician: To the best of eliner: On the basis of e	xamination							
	the I	Medi	one)	and manner state			29c. License					``
	5 N K T	_	29b. Signature and title of certifier	111.	1.						e signed (Mont	
	1.1		( STARRAIN)	TILL N	11)	- \ (=		64029		Dece	mber 3,	2007
	2011		30. Name and address of person who o	00-11	/ /	a) (Type,	KN Drive	P.I.	ille, M	1	20050	
	Sta	te	Brandin Fak MD 31. Date filed (Month, Day, Year)	32 Registrar	Signature	CENT	ILT TO IT	NOCKU	iju, M	U L	-0330	
	Registr		DEC 1 0 200	7 Raters.	K	do	relie					
		204		The state of the s	_~	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Marion C. Faved /Medical Nov. 30. 2007 7:10 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🖸 F Director 0klahoma 441-20-9655 83 04-22-1924 Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director MD Anne Arundel Odenton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 Odenton Road Apt. 406 21113 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify. 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Francis Collins <u>Helena</u> <u>Brooks</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3720 Grosvenor Dr. Ellicott City, MD 21042 Mary J. Mercedes / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-3-2007 Washington D.C. Glenwood Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End S nd S +asz Due to (or as a consequent of): **Physician** Dementia year resulting in death) /Medical Examiner Obstructue hronie 4000 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and the for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 VCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Marylahd 21215-0036

TOT

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0

Mirza Nusairee, MD

DEC 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

**ORIGINAL** 

MO

32. Registrar's Signature

29c. License number

1401 Madison Park Glen Burnie, Maryland 21061

D 0040579

29d. Date signed (Month, Day, Year)

11-30-07.

Physici /Medic Examir

Funeral Director

	1 - For State of Maryland / State Registrar		icate of L		- '		2007	39338
an	Decedent's Name (First, Middle, Last)     VIRGINIA BALDWIN FITZSIMONS				2. Date of Dea	D:	2007 Year	3. Time of Death
al	4a. Facility Name (If not institution, give street and number)	41	o. City, Town, or	Location of Death	December	<u> </u>	C. County of Dea	2:20P M
er	6111 Bellingham Court		Baltimore	e			Baltimore	
	5. Social Security Number 6. Sex 1		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da MArch 27	h v, Year <b>19</b> 0	)_   .Cc	thplace (State or Foreign ountry) ginia
	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location	on					10d. Inside City Limits
ctor	Maryland Baltimore Baltimo	re						1 □Yes XXX
To Be Completed by Funeral Director	6111 Bellingham Court	1	10f. Zip Code 2121(	)		10g. C	itizen of What Co	ountry?
nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes ★★ No	13. Was	Decedent of His es, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit	
by F	1 □ Never Married 2 □ Married 1 □ Yes XX No If Yes, Give Year or Dates:	1 🗆	Yes XX No	Specify:			Specify:	White
eted	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent (Give kind	's Usual Occupa d of work done d	ation Juring most of work	king	16b. l	Kind of Business	/Industry
duc	Elementary/Secondary (0-12) College (1-4or 5+)	Homema		)		0.	wn Home	
Se C	17. Father's Name (First, Middle, Last)			18. Mother's Nam				
To E	Bernard Coleman Baldwin			Mary Be				
	William Griffin Morrel Jr Son 6	Beechda	ale Road (	nd Number or Ru Baltimore,				Zip Code)
	I IM Burial 2 I ICremation 3 I Hemoval from State 1	-	on (Name of ory or other place		Date		_ocation - City or	
	4 ☐ Donation 5 ☐ Other (Specify) Spring 21 Signature of Funeral Service Licensee	Hill Co	emetery	12/1! s of Facility Mit	o/U/ chell_Wier	Lynd	chburg, Vi	rginia Home Inc
	Xennes Oleken Kenaku						ore Maryla	
	23a. Part1. Enter the dispase, or complications that caused the death. Descriptions shock, or heart failure. List only one cause on each line.	Do not enter th	ne mode of dying	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	عــــــــــــــــــــــــــــــــــــــ						Onset and Death 48 40 w
	Due to (or as a consequent	ce of): Ste	10313					5 years
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence consequence)  C. Due to (or as a consequence)							
kami	Cause (Disease or injury that initiated events c c Due to (or as a consequent	co of):						
ža E	Due to (or as a consequent	00 01/1						
ledic	G							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de- 4 ☐ Pregnant at time of death	ath 3 □Ect	topic pregnancy her <i>(sp</i> ec <i>ify)</i>				23d. Date of de Month	livery Day Year
y P	Part II. Other significant conditions contributing to death but not resulting	•	rlying cause give	n in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
ted k	Congestive heart Failure				1 🗆 '	es a	2 <b>1</b> No 3 □ P	robably 4 □Unknown
Comple	Osteoporo sig				24a. Was autor perto 1□ Yes		prior to death?	utopsy findings avallable completion of cause of cause of
Be	25. Was case referred to medical examiner?		Othe	26. Place of Dea				
: To	27. Manner of Death 28a. Date of Injury 28	Outpatient :	3 DOA Sunday 28c. Injury Work	4 ☐ Nursing H	ome 5 Residence 1 28d. Describe 1		6 □Other (Speury occurred	ecify)
atior	1 █️Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		? /es 2 □ No				
ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street,	factory, office		28f. Location (5 City or Tox	Street a vn, Sta	and Number or R te)	ural Route Number,
Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	and/or invest	tigation in my or	ninion death occu	read at the time	data a	nd place, and du	o to the cause(s)
Me	29b. Signature and title of certifier	· —	29c. License	number	3	29d. D	ate signed (Mon	th, Day, Year)
	30. Name and address of person who completed cause of death (Item 23	a) (Type, Prin	1) 201	N 18	2000	87	Sec.	th, Day, Year) b, 2007 Ithmare
ite	31. Date filed (Manth, Day, Year) 32 Registrar's Signature		0 50 1	7.0	~ 167	3 1	, , , , , , ,	in mark
ar	31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature	15084						

10

Sta Regist

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 10: 49 A M **Physician** Mary C. Griffith 5 December 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2000 Months Days Hours Min 217-18-6598 Director 15,1921 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show la or 28a-f sh t be notified a Dundalk 1 ☐ Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23a Funeral United States 7604 Poplar Road 21222 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Specify Specify. **3** Widowed 4 □ Divorced White Completed er than "nature, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Proctor & Gamble Co. Laborworker of Health and Mental Hygik Item 27 Is marked other I other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Dorsch Frank Gièse ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph J. Griffith (Son) Item 27 I 311 Barksdale Road Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/8/2007 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Table Wise Ave Dundalk, Maryland 21222 2, Drow 23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) respirator Hour /Medical Due to (or as a consequence f): Examiner 12 Hours Sequentially list conditions Aspiration cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed iding physician and ise as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 donknown been si 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient ၉ 2 ER/Outpatient 3 DOA After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes death. 2 🗌 No 2 ☐ Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

10

State Registrar 31. Date filed (Month, Day, Year) DEC 1

29b. Signature and title of cortifier

4940 Eastern Jennifer Cheng MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue

29c. License number

RES-000

Battimore,

29d. Date signed (Month, Day, Year) December 5, 2007

DHMH 17 Rev 1/2001

1306 Mazeland Drive  Bel Air  H  Funeral Director  Social Security Number   6. Sex   1 m Months	Year  97  3. Time of Death  1145 AM  Intry of Death  Harford Co.  9. Birthplace (State or Foreign Country)
4a. Facility Name (If not institution, give street and number) 1306 Mazeland Drive  5. Social Security Number 214-03-2640  Usual Residence of Decedent  4b. City, Town, or Location of Death Bel Air  4b. City, Town, or Location of Death Bel Air  4c. Cour Bel Air  7. Age (In yrs. last birthday) Yrs.  8 Date of Birth (Month, Day, Year) April 20, 1919	Harford Co.  9. Birthplace (State or Foreign Country)
Director  214-03-2640  Usual Residence of Decedent  1□ M 2√xF  88  Yrs. Months Days Hours Min. (Month, Day, Year)  April 20,1919	Country)
0	Maryland
Maryland Harford Bel Air  10e. Street and Number  10g. Citizen of Street and Number  1306 Maryland Prive	10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo
5 9   -   1306 Marcoland Drive   21015   175 de	of What Country?
Table MazeLand Drive 21015 United 13 Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? In John Mexican, Puerto Rican, etc.)  1 Never Married 2 Married 1 Never Married 2 Married 2 No Section 1 No. 1 No	ed States Race - American Indian, Black, White, etc.
Specify:    College (1-4or 5+)	white  ### Business/Industry
15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  8 Years  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  8 Years  16b. Kind of Give kind of work done during most of working life. DO NOT use retired)  8 Years  17b. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  8 Years  17b. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  8 Years  18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  8 Years  18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ery/Package Goods
To page of the pag	
John George Durkin  Mary Novakoski  19a. Informant's Name/Relationship (Type. Print)  Mrs. Linda D. Sandlass/Daughter 1306 Mazeland Drive Bel Air, Mary	
20a. Method of Disposition  20a. Method of Disposition  1 3 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22b. Place of Disposition (Name of cemetery, crematory or other place)  Bel Air Mem. Gdns. 12/7/2007  Bel  22c. Name and Address of Facility  Duda-Ruck Funeral Home of Dunda	on - City or Town, State
4 Donation 5 Other (Specify)  121. Signature of Funeral Service Licensee  22. Name and Address of Facility  Duda-Ruck Funeral Home of Dundal  7922 Wise Ave. Dundalk, Marylar	Air, Maryland
23a. Part 1. Enter the bisea of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head of the cause on each line.	Approximate Interval Between Onset and Death
Physician /Medical Examiner  Sequentially list conditions,	
Due to (or as a consequence of):	
The state of the s	
Description of the past 12 months?  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Date of delivery
FFEMALE: 23c. If yes, outcome pf pregnancy   1	Month Day Year
25e. Did lobacco use of	contribute to the cause of death?  o 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed?  1 Yes 2 No	ab. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?  1	
1	
1 Month, Day Year) Injury Work?  1 Month, Day Year) Injury Work?  2 Accident investigation M 1 Yes 2 No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Nur City or Town, State)	imber or Rural Route Number,
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	I manner as stated. ce, and due to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date sign	gned (Month, Day, Year)
30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)  James A. Dicke, M.D. 6701 N. Charks 5t. 4105 Towson,	4, 2007

			1 - State Amend #5 Per	State of Maryland FH G874 12/10	d / Depart <b>/07<sub>C</sub>ill</b>	ment of H	ealth and Death	Mental H	ygiene ()	7 3	9341
	Dhysis		1. Decedent's Name (First, Middle, Last					2. Date of I	Death		ime of Death
	Physic /Medi			ardner				Month 12	Oay	07 2	:42 pm
	Examir	ner	4a. Facility Nether (If not institution, give	street and number)		Baltin	Location of Dea	ith	4c. County	of Death	
	Funeral Director		ara TTTOT	7. Age (In yrs. Ia		f Under 1 Year flonths Days	If Under 24 Hr Hours Mir	s. 8. Date of 8 (Month, I	Birth (Payr) 46	9. Birthplace ( Country)	State or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locati	ion				10d. In:	side City Limits
	Many a-feb	tor	MD	Bo	ultim	ore.					Yes 2 □ No
	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow Iscal Examinar must be motilised at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?	···
	e 23a	ral	2814 Windso			21	216			WA	
	ter de	Funeral	11. Marital Status 1 Never Married Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 ☐ No		s Decedent of His es, specify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or find Rican, etc.)		e - American Ind k, White, etc.	ian,
036	ours at	by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 2 No	Specify:		Specify	Blac	k
5-0	natural',	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)	(Give kind	t's Usual Occupa d of work done d	uring most of we	orkina	16b. Kind of Bu	siness/Industry	
Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Clife. DO	NOT use retired	chnic		VA+	taco.	41
2	illed within Hygiene. Other than	Be Co	17. Father's Name (First, Middle, Last)			01 CC 18		me (First, Midd	e, Maiden Syrvan	1 W p. 7	щ
/lar	should be ad Mental marked c matic eve	ToB	James Gara	ther			Ola	Nac	McCI	ain	
<b>da</b> n	2 sho and I is ma	Ċ	144 Informant's Name/Relationship (Ty	pe, Print	19b. Mailing A	ddress (Stree) a	nd Number or F	lural Route Num	ber, City or Town,	State, Zip Code,	- 11
-	s 1 and of Heelth item 27 other to	8	20a. Method of Disposition	(COON)	274 7	W. No	rth tw	e, ba	Hu. M	D 216	216
Baltimore	0 ± 5		1 ☐ Burial 2 ★Cremation 3 ☐ F	Removal from State	metery, cremato	on (Name of ony or other place	2 121	Date	20c. Location	City or Town, St	ate
alti-	# 문원를 .	. 1	4 ☐ Donation 5 ☐ Other (Specify)  21. Signa \( \text{vr} \) of F neral Service Licens		een N	meand Address	of Famility	11107	Dain	Trore	ITAL
ã	Depa Impo eny i		1 Vaughn (	1. Treese	515	21 78/1	\ \K+1\	Pike	Balto.	MD 2	1729
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the death.	Do not enter th	ne mode of dying	, such as cardia		arrest,	Appro	oximate al Between
	Physician		Immediate Cause (Final disease or condition	Hepatocellu	1 0	veine					t and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque			7100				
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ance of):						
	ansit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events		ande ory.					- 10	
o,	en and rial-tra	Exa	resulting in death) Last	Due to (or as a conseque	ence of):						
68760,	eath certificate be executed attending physicien and for use as the burial-transit	dical									
_		<b>a</b>	IF FEMALE:	0- 4							
Box	death certif e attending id for use as	clan	in the past 12 months?	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal	leath 3□Ect	opic pregnancy			23d. Date Mon	of delivery th Day	Year
P.O.		Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	5 <u></u> Oli	ты ( <i>specity)</i>				,	
	The law requires that the de tte has been signed by the a page 2 should be detached f	by P	Part II. Other significant conditions con	tributing to death but not result	ing in the under	lying cause giver	n in Part I.	23e. Did	tobacco use contri	bute to the caus	e of death?
Records,	w require been sig should b							1 🗆	Yes 2□No	3 ☐ Probably	4 Donknown
ပ္တ	e law r has be	Completed						24a. Wa	s an 24b. W	ere autopsy fine for to completio	dings available
_		S						perf 1 ☐ Yes	ormed? 🦯 de	eath?	
<u>≅</u>	certifical rector, p	o Be	25. Was case referred to medical examiner?	ospital:				ath Check only			
ō	Phy ar this aral di	⊢⊬	1 ☐ Yes 2 ☑ No ☐ 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 3 8b. Time of	DOA Other	4   Nursing F		how injury occurre		
0	nding ath. r: Afte	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury : Work?	s 2 □No	200.000000	now injury occurre	· ·	
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director, to the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At hom building, etc. (Specify)	e, farm, street,	factory, office		28f. Location City or To	(Street and Number	r or Rural Route	Number,
	pitel (  purs al  pral D  illed it		One Contiller								
	Hos 24 ho Funi etely f	Medical	29a. Certifier 1 ✓ Certifying Phys (Check only 2 ☐ Medical Examir one)	sician: To the best of my knowl ser: On the basis of examinatio and manner stated.	edge, death occ n and/or investi	curred at the time gation, in my opi	, date and place nion, death occu	e, and due to the urred at the time	cause(s) and man date and place, ar	ner as stated. nd due to the ca	use(s)
	To the within To the complex	Me	29b. Signature and title of certifier	CITO III AI III OI SIAIBU.		29c. License			29d. Date signed		
ì			Harda 00	mn				17644			
	4	-	30. Name and address of person who con	mpleted cause of death (Item 2	3a) (Type, Print	1/491/1	ויו נפדע	^			
سيني	0		HMELIA KAND	ALLMD 11	DNORTH	6 Ree	NC STR	eet B	12/4/2 ALtimare	ms 21	201
8	Stat Registra		31. Date filed (Month, Day, Year) <b>DFC 1 0</b> 2007	32. Registrar's Signatur	South			,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HYLOCK DECEMBER 6, 2007 22:04 WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHN'S HOPKIN'S BAYVIEW MEDICAL CENTER BALTIMORE Birthplace (State or Foreign Country) ear If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 x M 2 □ F Months Hours Director 218-16-1598 11/3/1924 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at ¥∏Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21224 USA Fairmount Ave. 3504 E. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐ Yes 2☐ No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Labor Gand Leader 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Harry Hylock Edna Mae Weber 19a. Informant's Name/Relationship (Type. Print) Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean M. Long 3504 E. Fairmount Ave., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 → Burial 2 □ Cremation 3 □ Removal from State 12/10/07 Baltimore, MD 4 Donation 5 ☐ Other (Specify) Sacred Heart Jesus 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. FH 263 S. Conkling St. Baltimore, MD 21224 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the dise ve, shock, or heart failur. L Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PHEUMONIA WEEK /Medical Due to (or as a consequence of) Examiner MALIGNANT 2 WEEKS PLEURAL EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit ADENOCARCINOMA OF UNKNOWN PRIMARY 6 MONTHS Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown CHRONIC LYMPHOCYTIC LEUKENIA Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending (Month, Day Year) 1 TYes 2 TNo M investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES- COC

State Registrar

JOSE LUIS LOPEZ 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, BALTIMORE, MD

32. Registrar's Signature

**ORIGINAL** 

DECEMBER 6, 2007

DEC 1 0 2007

			1- For State of Registrar	Marylan		artment of H		ınd Men			7 39343
	Physici		Decedent's Name (First, Middle, Last)	beth J	Tane Hi		Jour		Date of Death Month	Day Yea	3. Time of Death
1000	/Medic Examin		4a. Facility Name (If not institution, give street and numb	er)		4b. City, Town, or			ecember	4c. County of De	
	Funeral Director			Age (In yrs. I	last birthday) Yrs.	Dunda If Under 1 Year Months Days	alk If Under 2 Hours	Min. (	Date of Birth (Month, Day, Y		irthplace (State or Foreign Country)
	D		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	cation			ay 10,1	925   F	ennsylvania  10d. Inside City Limits
	ith the Ma or 28a-f s	Director	Maryland Baltimore  10e. Street and Number			10f. Zip Code	Dun	ndalk	10g	. Citizen of What (	1 □Yes 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral [	7546 Old Battle Grove  11. Marital Status  12. Was Decede Armed Force	ent Ever in U.	.S. 13. V	212 Vas Decedent of His f Yes, specify Cuba		in? (Specify , Puerto Rica	Yes or No-	United S  14. Race - An Black, Wi	nerican Indian,
-0036	hours afte	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2:  3 ※ Widowed 4 ☐ Divorced		1		Specify:			Specify:	White
21215-0036	1 within 72 giene. r than "na the Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4  12 Years	or 5+)	(Give life. E	kind of work done d OO NOT use retired OMemaker	luring most ( )	of working	10	ib. Kind of Busines Own H	·
and	2 should be filed and Mental Hygi is marked other aumatic event, t	To Be C	17. Father's Name (First, Middle, Last) Michael Coyne		<del>_</del>			,	st, Middle, Ma	iden Surname)	Office .
Maryland	d 2 should the and Ment	F	19a. Informant's Name/Relationship (Type. Print) Mr. Jay W. Hidden (Son)			g Address <i>(Street a</i>	and Number	r or Rural Ro	ute Number, C	City or Town, State	
altimore, I	Pages 1 and 2 nent of Health ant; if item 27 i	15	20a. Method of Disposition  XXBurial 2 □Cremation 3 □Removal from Sta	ile	Place of Dispos emetery, cren	sition (Name of natory or other place	9)	Date	20	c. Location - City of	
Baltin	permit. Pag Department Important; i any injury o		4 Donation 5 Other (Specify)  21. Sign tury of Funeral purvisors in security	Ho	22. Dt	ll Mem. G Name and Addres uda-Ruck	s of Facility Funera	al Hom	ie of D	Middle R	Ing
I	E C		23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death		122 Wise	Ave.	Dunda	ilk, Ma	ryland 2	1222 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or	as a consequ	uence of):	COPO	>				Years
9	uted	Examiner	Cause (Disease or injury	as a consequ	uence of):						1
8760,	ate be executed objection and the burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (or	as a consequ	uence of):						
O. Box 6	the death certific y the attending p ached for use as	Physician/Medi		n 2 □ Fetal t at time of de	I death 3□	Ectopic pregnancy Other (specify)				23d. Date of d Month	elivery Day Year
ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to deat	n but not resu	ulting in the un	derlying cause give	n in Part I.		23e. Did tobac		to the cause of death?  Probably 4 Unknown
Vital Records,	The law ate has b	Completed							24a. Was an autopsy performer 1□ Yes 2	prior to	
or VII	yh sir idi	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpa	atient 2 🗆 l	ER/Outpatient	Other			eck only one) 5 ⊠Residenc	e 6 □Other (Sp	ecify)
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Day Year)	28b. Time of Injury me, farm, stre	28c. Injury Work M 1 ☐ Y et, factory, office		28d.	Describe how	injury occurred	Rural Route Number,
	he Hospit in 24 hours he Funera pletely fille	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the besidence of Medical Examiner: On the basis and manner	s of examinati	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and inion, death	place, and o	due to the caus the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
}	To t To t	Ž	29b. Signature and title of certifier  Yurge (Culton)	me	>	29c. License	number 8 9		29d.	Date signed (Mor	nth, Day, Year)
	5 Stat		29b. Signature and title of certifier  July Culture  30. Name and address of person who completed cause of the control of the	f death (Item	23a) (Type, P	Print) 7835	- Eas	st Pe	intm	all BA	mp21229
	Registra	ar	DEC 1 0 2007	La Die	STORA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hydiene

			1 - State Registrar	Otato of Ivia		ertificate of D		,		O "	00011
ı	Physic	ian	1. Decedent's Name (First, Middle, La	,				2. Date of Dea	_	J-1-	3. Time of Death
	/Medi	cal	As Franklin Mark Mr. 11 Mark Mark	Elmer	L. Hal	1 , Sr.		Month Decemb	per 4,20	Year 07	3:45 P M
Ä	Exami	ner	4a. Facility Name (If not institution, given 7864 Kavanagh R			4b. City, Town, or L			4c. County o		
	Funeral	7	5. Social Security Number 6. S		(In yrs. last birthda	Duno	If Under 24 Hrs.	O Date of Birth			ore Co.
	Director		224-20-2568 Usual Residence of Decedent	<b>X</b> M 2□F 86	N/	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct. 12	Year) 2,1921	9. Birthpla Country Virg	ace (State or Foreign ry) Jinia
	irylan ihow		10a. State 10b. County		10c. City, Town or	ocation				100	d. Inside City Limits
	Ba-f s	Director		imore			Dunda	lk			1 ☐ Yes 2 🔼 No
	with the	Dia	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	nat Countr	y?
	eath	Funeral	7864 Kavanagh			21222			United S	State	:S
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: V	)	. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2KI No	panic Origin? (Spe Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race Black,	- American White, etc Whi	tc.
5	"natu	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dec	edent's Usual Occupation	on		16b. Kind of Busi		
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	, I	e kind of work done dur DO NOT use retired)		ng			
<b>d</b> 2	filed Hygi Sther		6 Years 17. Father's Name (First, Middle, Last)		C:	rane Operat		(F)	Steel		stry
lan	lental fental rked c	To Be	Walker Henry			18	8. Mother's Name エゐa F	(First, Middle, N Bradley	Maiden Surname)	,	
ary	shou and M	_	19a. Informant's Name/Relationship (7		19b. Mail	ing Address (Street and			City or Town St	tato Zin C	and a l
Σ.	and 2 ealth n 27 i		David Hall	(Son)		9 Coralthor			River, N		21220
Ore	ges 1 t of H if iter or oth		20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		osition (Name of ematory or other place)			20c. Location - Ci		
<u></u>	t. Partmen		4 □ Donation 5 □ Other (Specify	)		ill Cemeter	v 12/9/	/2007	Castlewo	50d	177
Ba	Depar Impo any ir		21. Signature of Juneral Service Licen	D. Lees	2 1	2. Name and Address of Duda-Ruck F	of Facility Funeral F	Home of	Dundalk.	Inc	
			23a. Part1. Enter the disease, or comp shock, or heaviallure	dications that caused the cause on each line.		922 Wise A ter the mode of dying, s	such as cardiac or	respiratory arre	aryland st,	A	pproximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Can	as 1	lader				Ö	iterval Between Inset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	100009					
1 . 2		e.	Sequentially list conditions,	b. Due to (or as a c	onsequence of:						
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events	240 10 (01 43 4 0	onsequence or).						
oʻ	icate be executed physician and s the burial-transit		resulting in death) Last	c Due to (or as a c	onsequence of):						
68/60,	ate be nysicia he bu	Medical		d							
õ ×	certificate be executed ding physician and see as the burial-transit	Med	IF FEMALE:								
ň	death d for u	hysician/		23c. If yes, outcome pf 1 □Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		y Year
'n.	The law requires that the site has been signed by the bage 2 should be detached.		Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause given in	Part I.	23e. Did toba	acco use contribu	te to the c	ause of death?
	equir							1 ☐ Yes			y 4 Unknown
טַ	law r las be	Completed						24a. Was an	24b. Wer	e autopsv	findings available
		5						autopsy performe 1 Yes 2	ed? prior	r to comple th?	etion of cause of
= :	hysician: The law his certificate has t I director, page 2 s	D	25. Was case referred to medical examiner?	Inonital.		26	. Place of Death (		No 1	res ZL	7 140
5 7	Phys ral dir	0	1 Yes 2 No	lospital: 1 ☐ Inpatient 28a. Date of Injury			<b>Avursing Home</b>	5 Residen	ce 6 □Other (5	Specify)	
5 :	or Attending Phy after death. I Director: After this d in by the funeral d	LION	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) 28b. Time of Injury	28c. Injury at Work?	28	d. Describe how	injury occurred		
2	Atter	200	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	At home, farm, stre			Logation (Ctus	-4		
5	ospital or Attend hours after death. Ineral Director: /	Certification:	4 I nomicide	building, e.c. (S	Specify)	, and the same of	200	City or Town,	et and Number of State)	r Hural Ro	ute Number,
1	o the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it		29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	iclan: To the best of m ner: On the basis of exa and manner stated.	y knowledge, death amination and/or inv	occurred at the time, d	late and place, and	d due to the cau at the time, date	se(s) and manne	r as stated	d. cause(s)
4	To th comp	2	29b. Signature and title of certifier			29c. License nun			. Date signed (Me		
			1 /2016	1801				1			
	C+1	3	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, F	Print)	1		cem	46	(000)
1:	5+1		Masca	BOB m	1 21,	Print)  Mai	O Rec	tus	~ ~	2/1	25
	State Registra		DEC 1 0 2007	Registrar's	Signature Appl	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #17, perFH, C874, 12/14/07 TT Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 /Medical 1410 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TREET And 7. Age (In yrs. last hirthday) BALTIMORE 501 11048 STREET 410 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 M 2□ F 214-84-840 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Md. Baltimore 1XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event. 501 Dolphin Street Apt. 1410 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Shoe Warehouseman 12th grade D. Myers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Handy, Sr. Vonzella O'Neal Willie Woodrow 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mother 1003 Valley Street, Baltimore, Md. Vonzella Handy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11-28-07 King Mem. Pk. Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 ane Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) THERSO /Medical Due to (or as a consequence of): Examiner IA BETE. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examme been signed by the attending physician and should be detached for use as the burial-transit PER law requires that the death certificate be execute TENSION Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 1 0 2007

1) A L L / +
32 registrar's Signature

			2.	and / Depart	tment of Health and I	Mental Hygie	•	39346
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)  5 + (-1)2 abeth Nursing (		Ward b. City, Town, or Location of Death Baltimore	2. Date of Death Month Decemb	Day Year 200 4c. County of Death	3. Time Death
	Funeral Director				Il Under 1 Year II Under 24 Hrs. Months Days Hours Min.	(Month, Day, )	(ear) 9. Birth Cou. 1915 Penr	place (State or Foreign ntry) Isylvania
	Maryland f ehow led at	ō		City, Town or Locati	tion			10d. Inside City Limits 1 ▼ Yes 2 □ No
	with the f	Direct	10e. Street and Number 3320 Benson Avenue		10f. Zip Code		g. Citizen of What Cou	ntry?
936	72 hours after death with the Maryland naturel', or Iteme 23a or 28e-f ehow dissal Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Swidowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		21227  Is Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerl  Yes 21XNo Specify:	pecify Yes or No- lo Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
21215-0036	within 72 horens. ene. then "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	life. DO	nt's Usual Occupation Id of work done during most of work NOT use retired)  S Manager	rking	Sb. Kind of Business/Ir	ndustry
Maryland 2	ould be filed Mental Hygi arked other atic event, to	To Be Co	17. Father's Name (First, Middle, Last)  Thomas Matthew Henderson		18. Mother's Nar Rache1		aiden Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic event, the Medical Examinar must be notified at another.		1 Burial 2 Cremation 3 Removal from State	22 Edm	Address (Street and Number or Ringle Romandson Ridge Roman (Name of tory or other place)  rk Cemetery 12/8	ad; Caton		ryland 21228 own, State
Baltir	permit. P Departme Importen any injur		21. Signature of Funeral Service Licensee	22. N Fun	Name and Address of Facility St Leral Home of Ca 10 Edmondson Ave	erling As tonsville	hton Schwal	b Witzke
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the dishock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	eath. Do not enter to the property of the prop	the mode of dying, such as cardiar			Approximate Interval Between Onset and Death Y-PWS V-PWS V-PWS V-PWS
D. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burrait ransit.	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown  Due to (or as a constant of the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	gnancy etal death 3⊟Ec	ctopic pregnancy other (specify)		23d. Date of deliving Month	ery Day Year
ds, P.O	uires that th signed by t lid be detach	by	Part II. Other significant conditions contributing to death but not	resulting in the unde	erlying cause given in Part I.		acco use contribute to	1 4
il Records,	The law requir sate has been si page 2 should	Completed	Chronic atrial fib	rillati	m	24a. Was an autopsy perform	ed? prior to co	opsy lindings available ompletion of cause of
on of Vital	nding Physician: The la th. : After this certificate hav s funerat director, page 2	To Be	25. Was case referred to medical examiner?  1		100	ath (Check only one Home 5 Resider 28d. Describe how	ice 6 Other (Speci	(y)
Division	al or Attendin s after death. sl Director: Afi sd in by the fur	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spi	t home, larm, street ecify)	t, lactory, office	28l. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical (	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death or ination and/or inves	ccurred at the time, date and place stigation, in my opinion, death occu			
	To t Com	×	29b. Signature and title of certifier // // // // // // // // // // // // //	20	29c. License number : D55391	29	d. Date signed (Month,	Day, Year)
	Sta Registr	-	30. Name and address of person who completed cause of death (in the pay, Year) 2007 Registrar's Signature Pay, Year) 2007		enue, Balt	imore,	Marylan	1d 2/22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9874 12-13-07 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Joseph C. Hlavin Jr. 10: 30 AM December 6 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore HOSPITA Johns Hopkins 8. Date of Birth (Month, Day, Yea. 1/16/1933 Birthplace (State or Foreign Country) Funeral Months 1**X**] M 2□ F 213-30-3048 74 Maryland Director Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No FL Director Big Pine Kev Monroe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33043 USA 29107 Guava Lane Examiner must Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 1 ☐ Never Married > Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√2 No Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Monee. Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph C. Hlavin, Sr. Lillian F. Bromer P 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14204 Dove Creek Way Unit 308 Sparks, MD 21152 Susan F. Hlavin / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Remova! from State 12/8/2007 Hilltop Serv. Corp. Towson, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Maryland 21204 21. Signature of Funeral Service Licensee Towson. a Melin 1050 York Road Ruck Towson Funeral Home. Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 hours **Physician** ulgal sepsis /Medical Examiner Sequentially list conditions, any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed cell lymphoma Division or Vital Records, P.O. Box 68760,矣 burial-tran attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? I Director: After t d in by the funera Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 6. 10+1 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who compl Kendall Moseley, The Johnstopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287
31. Date filed (Month, Day, Year) | 32. Resistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_ For		St	ate of Ma	arylan	d / Depa	artmen	nt of h	lealth and	Mental H	ygien	е		
	1 - State Registrar					Cei	rtificat	e of	Death		Reg. N	0.21	07	39348
	1. Decedent's Name	e (First, Middl	le, Last)					_		2. Date of D		ay	Year	3. Time of Death
in al -	AGNE	S ISAB	ELLE F	IOFMANN						Decem				6:23a <sup>M</sup>
er	4a. Facility Name (I			t and number)			4b. City,	Town, o	r Location of Dear	h	4	c. County	of Death	1
	Holy Cro						1		Spring			Mong		
	5. Social Security N		6. Sex 1 ☐ M			last birthday) Yrs.	Months	Days	If Under 24 Hrs Hours Min	(Month, L	Day, Yea		COL	place (State or Foreign intry)
	214-28-8 Usual Residence of			XX	79					Sep 2	3, 1	.928	M	aryland
	10a. State	10b. County			10c. City	y, Town or Lo	cation							10d. Inside City Limits
ģ	MD	Princ	ce Geo	rge's		Laurel	L							1 □ Yes 2□No
ire	10e. Street and Nur	mber			1		10f. Zip	Code			10g. C	itizen of V	What Cou	intry?
Completed by Funeral Director	8900 Mon	tpelie	r Driv	re				2070	8		υ	.S.A		
ne	11. Marital Status		/	Vas Decedent Armed Forces?		S. 13.	Was Dece	dent of F	lispanic Origin? (S an, Mexican, Pue	Specify Yes or Note Rican, etc.)	lo-		e - Amer	ican Indian, etc.
Z Z	1 Never Marri			☐ Yes 2 🔀 ] f Yes, Give	<b>Y</b> o		1 □ Yes		Specify:	,		Specify	<i>/</i> ·	
Q Q	3 <b>∑ W</b> idowed			ear or Dates:		   40- D	da atta Ulass	-10	-Man		Lan		W.	hite
lete	·	15. Deceden cify only highe	nt's Education est grade con	n mpleted)		16a. Deced	kind of wo	al Occup ork done	ation during most of wo d)	rking	16b.	Kind of Bu	usiness/li	ndustry
Ĕ	Elementary/Seco Grade 11	ndary (0-12)		College (1-4or 5	5+)		nemak		•/			Own I	Home	
	17. Father's Name	(First, Middle,	Last)						18. Mother's Na	me (First, Midda	le, Maide			
o Be	Charles 1	Pease							Evely	n Galle	ry			
_	19a. Informant's Na	ame/Relations	ship <i>(Type. F</i>	Print)		19b. Mailir	ng Address	s (Street	and Number or Fi	ural Route Num	ber, City	or Town,	State, Z	ip Code)
	George A	. Hofma	ann, J	r./ som	ı	8900	Mont	perl	ier Driv	e Laur	el,	Mary:	land	20708
	20a. Method of Disp		4 TD		20b. P	lace of Dispo	sition (Name	me of other pla	ce)	Date	20c.	Location -	City or T	own, State
	14∑18urial 2   4 ☐ Donation			val from State	St	. Mary	's C	emet	ery   12/	7/2007	La	urel	, Ma:	ryland
	21. Signature of Fu	ineral Service	Licensee			22   I	Name ar	nd Addre	ss of Facility Funeral	Home.	P.A.			
	LITS	>4		/M	00770	3	313 Ta	albo	tt Avenu	e Laur			land	20707
	23a. Part1. Enter the shock, or hea	he disease, rt failure. Lis	complication	ons that caused ause on each li	the death ne.	n. Do not ent	er the mod	de of dyi	ng, such as cardia	c or respiratory	arrest,			Approximate Interval Between Onset and Death
	Immediate Cause (		a	Cardio	Resp	irator	y Ar	rest						Onset and Death
	resulting in death)			Due to (or as	a consequ	uence of):								
<u></u>	Sequentially list con	nditions,	b	Due to (or as	2 00000000	ionos of):							-	
Examiner	Sequentially list confirming any, leading to im Cause (Disease or	injediate njing injury	<	Due to (or as	a consequ	derice or).							- 4	
xar	that initiated events resulting in death) I	•	c	Due to (or as	a consequ	uence of):								
dical E														
ψ.			u											
<u>N</u>	IF FEMALE: 23b. Was deceden	t pregnant		f yes, outcome			- · ·					23d. Dat	te of deliv	very
Cia	in the past 12 1 ☐ Yes 2 ☐	months?		1□Live birth 4□Pregnant a			]Ectopic p ] Other <i>(</i> s <i>t</i>					Мо	nth	Day Year
hys			1											
<u> </u>	9 ☐ Unknown			∃∐Unknown								_		
2	Part II. Other signif	ficant conditi		uting to death b	ut not resu	ulting in the ui	nderlying o	cause giv	en in Part I.	23e. Dic	tobacco	use cont	ribute to	the cause of death?
ed by		ficant conditi		uting to death b	ut not resu	ulting in the ui	nderlying o	cause giv	en in Part I.		tobacco		ribute to 3 ☐ Pro	_
pleted by	Part II. Other signif	icant conditi		uting to death b	ut not resu	ulting in the u	nderlying c	cause giv	en in Part I.	1 <u></u>	] Yes s an	2 No	3 ☐ Pro	obably 4 Unknown
completed by	Part II. Other signif	icant conditi Y Arternsion	cy Dis	uting to death b	ut not resu	ulting in the u	nderlying c	cause giv	en in Part I.	1 C 24a. Wa	Yes s an	2□ No 24b.	3 ☐ Pro Were aut prior to o	obably 4 Hinknown  opsy findings available ompletion of cause of
ge Completed by	Part II. Other signification Coronary Hyperter Diabetes 25. Was case refer	Melli	ty Dis	ating to death b	ut not resu	ulting in the u	nderlying c		26. Place of De	1 ☐ 24a. Wa aut per 1 ☐ Yes	Yes s an opsy formed? 2XX	2□ No 24b.	3 ☐ Pro	obably 4 Unknown
To Be Completed by Physician/M	Part II. Other signification Coronary Hyperter Diabetes 25. Was case referexaminer? 1   Yes   283	ricant condition  Arter  Arter  Asion  Melli  Fred to medica	itus Hosp	ating to death b	ent 2 🔀	ER/Outpatien	nt 3 DC	Oth	26. Place of De er: 4 \( \) Nursing I	1 ☐ 24a. Wa aut per 1 ☐ Yes	Yes s an opsy formed? 2XM	2 No 24b.	3 ☐ Pro Were autorior to codeath? 1 ☐ Yes	obably 4 Thinknown copsy findings available completion of cause of 2 XX
	Part II. Other signification Coronary Hyperter Diabetes 25. Was case refer examiner? 1   Yes 200	Melli red to medica	itus Hosp	uting to death b	ent 2 🔀		nt 3 DC		26. Place of De er: 4 \( \) Nursing I	24a. Wa aut per 1□ Yes ath <i>(Check only</i>	yes s an opsy formed? 2XX	2 No 24b.	3 ☐ Pro Were aut prior to co death? 1 ☐ Yes er (Spec	obably 4 Thinknown copsy findings available completion of cause of 2 XX
	Part II. Other signification Coronary  Hyperter  Diabetes  25. Was case referexaminer?  1 Yes 200  27. Manner of Deatt 1 1 Natural 2 Accident	V Arternsion  S Melli red to medica  No  Description  S Pendir investi	itus Hosp	ital: 1 Inpatie  Ba. Date of Inju (Month, Da	ent 2 🔀	ER/Outpatien 28b. Time ol Injury	nt 3 DO	DA Otr 28c. Inju Woi 1 □	26. Place of De er: 4 \( \) Nursing I	24a. Wa aut per 1	s an opsy formed?  2X M  r one) sidence	2 No 24b.	3 ☐ Pro Were autiprior to codeath? 1 ☐ Yes er (Spec	obably 4 All Inknown  copy findings available ompletion of cause of 2 XIX o
	Part II. Other signification Coronary Hyperter Diabetes 25. Was case referexaminer? 1	V Arternsion  S Melli red to medica	itus Hosp	uting to death b	ent 2 🔀	ER/Outpatien 28b. Time ol Injury	nt 3 DO	DA Otr 28c. Inju Woi 1 □	26. Place of De er: 4 □ Nursing I y at k?	24a. Wa aut per 1	s an opsy formed? 2XXX rone) sidence how inj	2 No 24b. No 6 Oth	3 ☐ Pro Were autiprior to codeath? 1 ☐ Yes er (Spec	obably 4 Thinknown copsy findings available completion of cause of 2 XX
	Part II. Other signification Coronary  Hyperter  Diabetes  25. Was case referexaminer?  1	Arternsion  S Melli red to medica No h 5   Pendir investi 6   Could detern	itus Hosp ggation not be nined	ital: 1 Inpatic 8a. Date of Inju (Month, Da	ent 2 🕱 ry y Year) ury - At ho	ER/Outpatien 28b. Time of Injury ome, farm, str	of 3 DC	Otr 28c. Inju Wor 1 y, office	26. Place of De er: 4 □ Nursing I y at k? Yes 2 □ No	24a. Wa aut per 1   Yes ath (Check only Home 5   Re 28d. Describe	s an opsy formed? 2XM rone) sidence how inj	2 No  24b.	3 Pro	obably 4 Number,
	Part II. Other signification Coronary  Hyperter  Diabetes  25. Was case referexaminer?  1   Yes   2xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	Arternsion  S Melli red to medica No  1	tus Hospi gation not be an an an an an an an an an an an an an	ital: 1 Inpatie Ba. Date of Inju (Month, Da) Be. Place of inj building, et	ent 2 🔀 ry y Y Year)  ury - At ho c. (Specify of my kno f examina	ER/Outpatien 28b. Time of Injury ome, farm, str	of 3 DC	OA Otr 28c. Injury Wor 1 U	26. Place of De er: 4 □ Nursing I y at k?	24a. Wa au per lumber l	s an opsy formed? 2X Mr. one) sidence e how inj	2 No  24b. Valoriand Numbute)	3 Pro	obably 4 Number,
Medical Certification: To Be Completed by	Part II. Other signiff Coronary Hyperter Diabetes 25. Was case referexaminer? 1  Yes 200 27. Manner of Deatt 1  1  1  Natural 2	Arternsion  S Melli red to medica No  b Could determ  XXCertifying	tus Hosping gation not be nined 2: Examiner:	ital: 1 Inpatie 8a. Date of Inju (Month, Da)  Be. Place of inju building, et	ent 2 🔀 ry y Y Year)  ury - At ho c. (Specify of my kno f examina	ER/Outpatien 28b. Time of Injury ome, farm, str	nt 3 DO	DA Otr 28c. Injun 1 □ y, office	26. Place of De er: 4 ☐ Nursing I y at k? Yes 2 ☐ No	24a. Wa au per lumber l	yes s an opsy formed?  an one) sidence how inj  (Street a own, Ste e cause e, date a	2 No  24b.  10  6 Oth  and Numb  (s) and ma  ind place,	3 Pro Were aut prior to c death? 1 Yes er (Spec red	obably 4 Number,

State Registrar

10

DHMH 17 Rev 1/2001

Rockville, Maryland

20850

15225 Shady Grove Road, # 208

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravi Passi, M.D.

31. Date filed (Month, Day, Year)
DEC 1 0

			For State Registrar	State of	Marylan	•	artment of F		and Mer		giene Reg. No 2	0.7	393	350
-	Physici	an	Decedent's Name (First, Middle)	e, Last)						Date of Dea		Year	3. Time of	Death
	/Medi		Inez Heckstal						N	VV	29,	£003	10.18	K AM
	Examir	ner	4a. Facility Name (If not institution STNA) HOSP			MORF	4b. City, Town, o		of Death	Y	4c. County	of Death		
to the second	Funeral		5. Social Security Number	6. Sex 1	7. Age (In yrs. i		If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birt (Month, Day	h v Year)	9. Birthpl	lace (State o	or Foreign
	Director		212-34-4973	1 □ M 2 💢 F	70	Yrs.	WOITINS Days	nouis				Mary]		
	land ow It		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					10	0d. Inside C	ity Limits
	Mary a-f sh ified a	żor	MD			Balti	more						1X Yes	2 □ No
	or 28% e noti	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of V	Vhat Coun	try?	
	ath wi	ral	5241 Cedgate				2120				USA			
	ter de items iner π	Funeral	11. Marital Status  1 XNever Married 2 Marr	12. Was Deced Armed For ied 1 ☐ Yes	ces?	S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Orig an, Mexican	gin? (Specify i, Puerto Rica	Yes or No- an, etc.)	- 14. Raci Blac	e - America k, White, e		
5-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	9		1 □ Yes 2 ሺ No	Specify:			Specify	bla	ck	
5-0	72 ho natur dical I	Completed	15. Deceden	t's Education st grade completed)		(Give	dent's Usual Occup kind of work done	durina most	of working	un	16b. Kind of Bu	usiness/Ind	lustry	
21	vithin ene. than "	ld m	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I	DO NOT use retired	d)	3		cocin1	CO 0111	ritu c	dm
d 21	filed v Hygie other t		17. Father's Name (First, Middle,	Last)		<u> </u>	unk	18. Mother	r's Name <i>(Fi</i>	rst, Middle,	Social  Maiden Surnam		ILY a	unk
lan	lid be fental rked c	To Be												
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural Re	oute Numbe	er, City or Town,	State, Zip	Code)	
	and and m 27 m 27 her tr		Joyce Brown/ca	regiver	loo. D		Cedgate	Road				206		
Baltimore,	iges 1 nt of H i if ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation			lace of Dispo emetery, crei	sition (Name of matory or other plac	ce)	Date		20c. Location -	City or To	wn, State	
Ħ	artmer ortant injury		4 □ Donation 5 □ Other (S		ate	22	Name and Addre	ss of Facilit	v					
Ba	permi Depar Impor any ir		21. Signature of Funeral Surfice	10 Clex	irector	Ва	Name and Addre ate Anat Itimore,	MD 2	21201			ore S	treet	
Я			23a. Pant. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the death	n. Do not ent	er the mode of dyir	ng, such as	cardiac or re	spiratory ar	rest,		Approximat Interval Bet Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. AS	CVID									
	Examiner			Due to (d	or as a consequ	uence of):								
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a consequ	uence of):								
	ecuted nd transit	Examiner	that initiated events	с										
8760,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (c	or as a consequ	uence of):								
687	ficate physi s the I	edica		d	. <u>.</u>									
Box (	he law requires that the death certificate be executed ine has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			le				23d. Dat	te of delive	ery	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 ⊡Fetai ant at time of de wn		Ectopic pregnancy Other (specify)	y 			Mo	nth	Day	Year
P.0	that the de led by the a detached	Phy	9 ☐ Unknown  Part II. Other significant condition			ulting in the co	adashina asusa ak	on in Dawl		220 Did to	obacco use cont	ribute to th		doath?
	iires tha signed d be det	by	Abdomina	Dart	. 1.	ining in the th		en in Fan i.		1 □ N				Unknown
Sor	requir	etec	1,100011 117 (30	· Morac	<u> </u>		3111			24a. Was			psy findings	availabla
Division or Vital Records,	he lav	Completed				-			-	autop perfo	rmed?	prior to con death?	npletion of c	ause of
ital		Be Co	25. Was case referred to medica	i i				26. Place	of Death (C		T	1 □ Yes	2 No	
r V	hysician: this certific al director,	To B	examiner? 1 ⊠Yes 2 No	Hospital: 1 ☐ Ir	patient 2 🕱	ER/Outpatier	t 3□ DOA Oth	ier: 4 □ Nui	rsing Home	5 ☐ Resid	dence 6 □Oth	er (Specify	1)	
0 0	ing F		27. Manner of Death 1 Manner of Death 5 □ Pendin	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury	Wor			. Describe h	now injury occur	red		
isio	I or Attendi after death. Director: A	cati	2 ☐ Accident investion 3 ☐ Suicide 6 ☐ Could in	not be 290 Place	of injury - At ho	me farm str	M 1 ☐ eet, factory, office	Yes 2 □ N		Location (9	Street and Numb	er or Rum	i Route Nur	nhor
DΞ	after Direct	Certification:	4 Homicide determ		g, etc. (Specif)		cot, lactory, office		201.	City or Tox		er or riara.	THOUSE HEAT	nber,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the la Examiner: On the ba and mann	sis of examina	wledge, deat tion and/or in	n occurred at the til vestigation, in my o	me, date an opinion, dea	d place, and th occurred	due to the at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(	s)
	To the H within 24 To the Fu complete	Me	29b. Signature and title of certifie	P			29c. Licens				29d. Date signe	d (Month,	Day, Year)	
		76	1/1/1	M.D.			D	533	FF.		NOVEM	BER	29,	2007
			30. Name an address of person	who completed cause			Print) NEST BE	こしてたり	ERE	Ave.	BALTI	MORE	e, MD	21215
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 1 (	# ALT	gistrar's Signa	ture	ant s							
	Hogisti	۷.	DEC 1	J LUUI KAN	SAL Y	27								

DHMH 17 Rev 1/2001

H ECIC STALL

LNEZ

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 6, 2007 1:28AM<sub>M</sub> **ESCORAL** HAWKINS LLOYD 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Center Towson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Days Hours February 20 , 1926 201-14-7106 81 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2□No Maryland | Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1406 Autumn Leaf Road 21286 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. XXYes 2 □ NoWWII 1 Never Married XX Married 1 ☐ Yes XX No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Broker Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Noah Ray Hawkins Florence Kendall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charlotte Cecil Hawkins Wife 1406 Autumn Leaf Road Towson, Maryland 21286 20a. Method of Disposition ABurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Providence Methodist Cem. 12/11/07 Towson, Maryland Donation 5 ☐ Other (Specify) gnature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AnceR montas M Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause before unorthing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r 28a-f show notified at

ms 23a or

. Hygiene. other than "natural", or Items ? ent, the Medical Examiner mu

Pages 1 and 2 should be filed within 72 hours after

h and Mental F

of Health a item 27 ls

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once.

altimore, Maryland 21215-0036

Funeral Director

þ

Completed

Be

Examine

Physician/Medical

<u>ک</u>

IF FEMALE:

Hospital or Attending Physician; The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit

Be Completed funeral director, ို After this Certification: after death.

I Director: A in by the fu within 24 hours aft To the Funeral Di completely filled in

Division or Vital Records, P.O. Box 68760,

10

To the

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

25. Was case referred to medical

5 Pending investigation

6 ☐ Could not be

DEC 1 0 2007

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3☐ Suicide

29a. Certifier

BMC

6701

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

29c. License number 25205

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

N. Charles St.

24a. Was an autopsy performed? Yes 2 No

1□ Yes

Other: 4 Nursing Home 5 Residence 6 Ofther (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

37 Registrar's Signature

3□ DOA

М

28c. Injury at Work?

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER Year **Physician** 09:58 PM NAOL JONES 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 K F 12-60-926 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 Ves 2 No Director 28a-f 10e Street and Number 10g. Citizen of What Country? 10f Zin Code item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be I Funeral death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Completed by 4 Divorced 3 Widowed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be f Health and Menta item 27 is marked -iseR ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOY Ron 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 remation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) 21. Signature uneral Service marc 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Juse (Final **Physician** IDIOPATHIC BRONCHIOLITIS OBLITERANS WITH ORGANIZING PNEWWAY 3 WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Esquentially list our unions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed as the burial-transi Mg g Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ ACQUIRED IMMUNE DEFICIENCY 2 No 1 Tes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? (es 2 No 2 1 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of/certifier

DHMH 17 Rev 1/2001

7

State Registrar Alcein

ADEKUNLE OBISESAN

31. Date filed (Month, Pay, Year)
DEC 1 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3001 SOUTH HANGVER STREET, BALTIMORE

RES 000

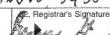
DECEMBER 09 2007

MARYLAND

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



December 7 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM BASKAKAN, 3455 WILKENS AVE BALTIMURE

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39354 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** RALPH BENJAMIN JOHNSON DECEMBER 1442 p 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BELAIR 8. Date of Birth (Month, Day, HARFORD CO 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex XXM 2□F Months Days Hours Min. NORTH CAROLINA 59 1948 153-40-7369 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XXNo MARYLAND HARFORD CO ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 159 W. DEEN AVENUE 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 □ No 1 ☐ Yes 21XX Completed by Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 12th grade TRUCK DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES JOHNSON မ ADEHINE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerlene Johnson/Wife 159 W. Deen Ave., Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 12-13-07 OWINGS MILLS, MARYLAND 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S. PHILADELPHIA BLVD., ABERDEEN, MD 21001 WM C proun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Shock Immediate Cause (Final 24 hours disease or condition resulting in death) Due to (or as a consequence of): NYDRONEPHROSIS 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): IF FEMALE 23c. if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Ves 2 No Hospital: Other: 4 Nursing Home 1 Sinpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

ed by sign page 2

**Funeral** 

Director

28a-f sh notified

a or

event, the Medical

other traumatic

Department o Important: If I any Injury or once. 들능

Physician

/Medical

Examiner

Hygiene.

Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 Is marked of

Maryland

timbre.

death with

use as the burial-tran certificate funeral after death.

Completed by Physician/Medical Be Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

To the Hospital o within 24 hours aft To the Funeral DI 511

State Registrar

DHMH 17 Rev 1/2001

and manner stated. 29b. Signature and Nie of certifier D0056296

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ppirchisapake Dr. Bei

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrar's Signatur

0 2007

6 ☐ Could not be

determined

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Department of Health and N Certificate of Death	_	. No. 2007	39355		
			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death		
13	Physici Medid		Rayfield Johnson		Nov 28.	Day Year 2007	11:38 PM		
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death			
			Southern Maryland Hosptial	Clinton		Prince Ge			
10	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Coul	place (State or Foreign		
-th	Director		240-60-5834 FAIN 201 67 Usual Residence of Decedent		Feb 14,	1940   Nort	h Carolina		
yland	at		10a. State 10b. County 10c. City, Town	or Location		1	Od. Inside City Limits		
Mar	a-f st iffied	ctor	MD Prince George's Suitla	and			1 □ Yes 2 No		
th the	or 28 e not	Director	10e. Street and Number	10f. Zíp Code	10g.	. Citizen of What Coul	ntry?		
ath wi	23a ust b		4909 Braumer Avenue	20746		USA			
er de	items ner m	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.Sunk	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
d 21215-0036 filed within 72 hours after death with the Maryland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: bla	ck		
Maryland 21215-0036 od 2 should be filed within 72 hours af	atura cal E	edi	15. Decedent's Education 16a.	Decedent's Usual Occupation	unk 16	 b. Kind of Business/In	dustry unk		
215 Fig. 22	in "na Media	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king				
21. d wit	giene er tha the	ĕ	unk unk						
E E	al Hy I oth	Be (	17. Father's Name (First, Middle, Last)	unk 18. Mother's Nam	e (First, Middle, Mai	iden Surname)	unk		
arylan should be	nd Mental Hygi marked other matic event, t	2							
<b>Jar</b>	t of Health and Men If Item 27 is marke or other traumatic		1	Mailing Address (Street and Number or Rul			Code)		
	Health em 27 ther t		1 - 8 - 7 - 7 - 7	09 Braumer Avenue Su					
Baltimore, permit. Pages 1 ar	nt of h		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place)	200	c. Location - City or To	own, State		
	Department Important: I any Injury o once.		4 □ Donation 5 ☑ Other (Specify) in state	22 Name and Address of Facility					
Balt permit.	Departi Importa any Inju once.		21. Signature of meral Since Licensee Ronal S. Wade, Tirector	State Anatomy Board		Saltimore S	street		
E	124		23a. Part1 Enter the disease, or complications that caused the death. Do n shock or heart failure. List only one cause on each line.			,	Approximate		
Ph	ysician		Immediate Cause (Final disease or condition	ParDi Faula	(1)	18	Interval Between Onset and Death		
	Medical		resulting in death)  Due to (or as a prisequence of	1): 1					
E	aminer		Sequentially list conditions.	Papi. Faila Parisviz Vouce CO					
D	±	iner	rary, leading to immediate cause. Enter Underlying Cause, (Disease or injury	1): C(N)	1)				
ecute	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C						
60°,	physician and s the burial-transit		Due to (or as a consequence of	D60 , C	HT.				
<b>68760,</b> tificate be executed	g phys as the	edical	d		-				
	attending properties of the second		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delive	erv		
deat a	e atte d for	Physician/M	in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 1 ☐ Vos 2 ☐ No.  4 ☐ Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year		
T. Gat the	been signed by the should be detached	hys	9 □ Unknown 9 □ Unknown						
S, T	gned oe de	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to the			
	en si	ted	- pasque		1 ☐ Yes	2 No 3 Prot	pably 4 Unknown		
I Hecords, P.O. Box The law requires that the death cer	as be	Completed	Anun'a.		24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of		
	certificate has t irector, page 2 s	50			performed	d2 death?	2□ No		
VI <b>tal</b> ician; ⊺	certific rector,	Be	25. Was case referred to medical examiner?		h Check onl one				
Or	this all dir	2	1 Yes 21 No 1 Inpatient 2 ER/Out			e 6 □Other (Specif	iy)		
	n. After t funera	io	Natural 5 □ Pending (Month, Day Year) In	ime of 28c. Injury at jury Mork? 1 ☐ Yes 2 ☐ No	28d. Describe how	Injury occurred			
DIVISION or Attending	after death Director: I in by the	ficat	3 Suicide 6 Could not be 28e Place of injury - At home, far		28f Location (Street	et and Number or Rura	al Route Number		
2 5	after I Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	in reduce rearrison,		
ospita	hours Inera Iy fille	alc	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the caus	se(s) and manner as s	tated.		
the H	in 24 t <b>he F</b> u	edical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	i/or investigation, in my opinion, death occui	rred at the time, date	and place, and due to	o the cause(s)		
Tot	within 24 hours after de <b>To the Funeral Direct</b> completely filled in by th	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,			
			14 m 11/12	4 D24208		11-28-6	//		
			30. Name and address of person who completed cause of death (Item 23a) (1	Type, Print) 8926, WOOC	youd	Rof I	101		
16	Sta	to	31. Date filed (Month, Day, Year)  32. Registrar's Signature	m) chat	n mo	1 20-	235		
37.	Sta Registr		31. Date filed (Month, Day, Year)  DF C 1 0 2007  See Registrar's Signature	parti					
			DECT O TOOL						

07-09	549
Mary	Kuka

lary Kuka		State of State Programmer State Stat	Maryland / Departme <i>Certifica</i>			Mental Hy	_	200	7 39356		
Physicia ledical Examin		Decedent's Name (First, Middle,Last)     Mary	Kuka				2. Date of Deat Month December	Day Year	3. Time of Death 1210 hrs		
		4a. Facility Name (if not institution, give str 3720 E. Lombard Street		41	b. City, Town, or Lo Baltimore	ocation of Death	December	4c. County of Dea			
Funeral Director		5. Social Security Number 6. Sex 217-22-1274 Fema	7. Age (In yrs. last birth	day) Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	_	1910 Fore			
Aaryland 28a-f show any 1 at once	Director	Usual Residence of Decedent  10a. State  MD  10b. County  10e. Street and Number	10c. City, Town o Baltim	r Locatio	on 10f. Zip Code		110	Oq. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No		
the N	Funeral Dire	1 Never Married 2 Married 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No	If Ye	21224 Decedent of Hispans, specify Cuban, I	anic Origin? ( Sp Mexican, Puerto		U.S.A.  14. Race - Ame White, etc. Whi	erican Indian, Black, te		
136 thin 72 hours after than "natural", edical Examiner	eted by	3 Widowed 4 Divorced If Your 15. Decedent's Education (Specify only his Elementary/Secondary (0-12)	ghest grade completed)  College (1-4 or 5+)	ecedent' uring mo	Yes 2 X No 's Usual Occupatio st of working life. I  's Lady	on (Give kind of v	vork done red)	Specify:  16b. Kind of Business  A.&G. C1			
ID 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than natic event, the Medical	Compl	17. Father's Name (First, Middle, Last)			18	3.Mother's Name	(First, Middle, M	Maiden Surname)			
2121 ould be f Mental marked	To Be	19a. Informant's Name/Relationship (Type,	Verga Print) 19b.			and Number or F	Rural Route Num	ber, City or Town, Sta	te, Zip Code)		
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		Rosemary Smith-  20a. Method of Disposition  1 X Burial 2 Cremation 3 F	granddaughter  Removal from State  St. 20b. Place of St. Cremato	37 Disposit ry or othe ohn	20 E. L tion (Name of ceme er place) s Cem.			t Balto 20c. Location - City of Jessup,			
Balting permit. Pa Departmet Importan injury or	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		T							
M ឧក្ខ័ន្ធ Physician	-	23a. Part I, Enter the usease, or complicati	ons that caused the death. Do not	26	3 S. Co	nkling	St. B	Funeral alto. MD est, shock, or heart	21224 Approximate Interval		
/Medical		failure. List only one cause on each li Immediate Cause (Final disease a. Ath	ne. erosclerotic Cardiovascula to (or as a consequence of):						Between Onset and Death		
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	to (or as a consequence of): to (or as a consequence of):								
executed an and al - transit	ia E	d									
ath certificate be attending physici or use as the buri	siciar		WALE: Vas decedent pregnant in the ast 12 months?  Yes 2 No. 9 takeoute 1 takeoute 1 takeoute 2 takeoute 1 takeoute 2 takeoute 1 takeoute 2 tak								
i, P.O. B ires that the de signed by the	d by Phy	and the second s	Unknown tributing to death but not resulting	in the ur	nderlying cause giv	en in Part I.		bacco use contribute to	to the cause of death?		
Records, The law require ficate has been si, page 2 should b	Completed						24a. Was autop perfor 1 ✓ Yes	sy prior to med? death?			
Vital Rec hysician: The this certificate I director, page	B	25. Was case referred to medical examiner?	tal: 1 Inpatient 2 ER/Out	patient		of Death (Check of Death (Chec		Residence 6 🗸 Oth	er: Scene		
ion of Vital tending Physician eath. tor: After this cert the funeral directo	ation: To	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation		ime of In	jury 28c. Injury			now injury occurred			
Division  To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fan				or Town, S	itate)	Rural Route Number, City		
To the Howithin 24 h To the Fu	Medical	one) 2 ✓ Medical Examiner:On	To the best of my knowledge, deat the basis of examination and/or inv manner stated.								
	Me	29b. Signature and title of certifier	AG		29c. License O.C.M			29d. Date signed (M. December 10, 2			
10		<ol> <li>Name and address of person who comp Laron Locke MD. Assistant</li> </ol>	,	Penn	Street, Baltim	ore, MD 212	01				
Sta		31. Date filed (Month, Day, Year) DEC 1 0 200	32. Registrar's Signature								
Registr DHMH 17 Rev 1/20	_	DEO 1 0 200		GINAL							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend itsus of Maryland, Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Kernahan 2. Date of Death 1. Decedent's Name (First, Middle, Last) Leonora A. Day Year Month 6:40 PM Physician Kera eon 00 December 7 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Johns Holking Bayvilly Cart of Her Examiner Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. December 1,1913 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F 212-42-9311 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b County 10a State 77 is marked other then "netural", or items 23e or 28e-f show traumatic event, the Medical Exercitivations to collided at 1 ☐ Yes 2X No Dundalk Maryland Baltimore **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 3108 Shortway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. I other then " Elementary/Secondary (0-12) College (1-4or 5+) Bank Data Processor 11 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ! Mary L. Ramsey Albert Gomez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2742 488 F83 Fe Road, Dundalk, Maryland 21222 19a. Informant's Name/Relationship (*Type*, *Pint*)

Marilyn R. Olszewski Daughter other 1 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery 20c. Location - City or Town, State December 20a. Method of Disposition ŧ permit. Pages Department of importent: If it eny injury or c 1 Burial 2 Cremation 3 Removal from State Glen Burnie, MD. 12, 2007 4 □ Donation 5 □ Other (Specify) 21 Signature of Fyneral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Phota Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary artery ream **Physician** /Medical Due to (or as a consequence of): nyper Hension
De to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and I-transit Due to (or as a consequence of) physician are the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical as signed by the attending I d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ insufficiency 1 Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoporosis autopsy performed? 1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 EN/Outpatient 3 DOA 1 Yes 2 10 this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier physician D59562 December 8, 2007 30. Name and address deperson who completed cause of death (Item 23a) (Type, Print)

The 114 Genzelg, Mp Bellman Mp 21214

31. Detailed (Marit Con York) 31. Date filed (Month, Da C 1 0 32 Registrar's Signature State 2007 Registrar DHMH 17 Rev 1/2001

ORIGINAL

07-09418	
Joel Kruh	

Joe	l Kruh		1- For State	State of	Maryla		partme <i>ertifica</i>			and	Menta	al Hyg			200	7 7	31	935	3 8
	Physici		1 Decedent's Name (First,	viiddle,Last)								2	. Date of De	ath	Year		me of De	ath	í
Me	dical Exam	iner	JOEL 4a. Facility Name (if not insi	ROBERT				- [4	KRUH De					Day er 4, 200			236 hrs	5	4
E			St. Agnes Hospita	reet and nu	mber)		41	Baltimo		ocation of i	Death		40. (	County of Dea		NI / A			
	Funeral		5. Social Security Number	6. Sex		7. Age (In y	s. last birtho	iay)	If Under	_	If Under 2		8. Date of E	irth(MM/DI	D/YYYY) 9. E		N/A ce (State	or	1
	Director		212-48-8049	1 X M	2F	6	1	Yrs.	Months	Days	Hours	Min.	03/09,	/1946		Country)	NY		
	any		Usual Residence of Decede 10a. State 10b. Co			10c. C	City, Town or	Locatio	n							10d	Inside C	ity Limits	7
	<b>*</b> .	Ļ	MD	BALTIM	ORE				MILI	5							Yes	•	1
_	Maryland 28a-f show d at once.	ecto	10e. Street and Number					11100	10f. Zip C				T	10g. Citize	en of What Co				1
1160	h the N 3a or otifice	I Dir	25 STRAWH	ILL CO	URT				21						ILS A				
-	ath wit items?	Funeral Director	11. Marital Status  1 Never Married 2		2. Was Dec Armed Fo		- 1		Decedent s, specify (				cify Yes or Nican, etc.)	lo- 1	<ol> <li>Race - Am White, etc.</li> </ol>		ndian, Bla	ack,	
	fter de l'', or i		3 Widowed 4	X 1 Divorced If Y	Yes es, Give Yea	2 <b>X</b> N	٥	1	Yes 2	No .	specify:			s	pecify:	WH1	TE		
	nours a natura (xami)	ed by	15. Decedent's Education		pares: nighest grad	le completed	) 16a. De		s Usual Oo st of working					16b. Kir	nd of Busines				1
	36 tin 72 l i. than "t	Completed	Elementary/Secondary (0	-12)	College (1	-4 or 5+)							<u>.,</u>						
	5-00 ed with lygienc other i	Com	17. Father's Name (First, Mi	ddle, Last)	5+		Į AI	IUKN	EY /				irst, Middle	, Maiden S	LAW urname)				$\dashv$
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	DAVID					KRU			JESS				SE	IFE	RT		
	MD 2 and 2 and 2 and 2 and 3 a	To	19a. Informant's Name/Rela		, Print ) [FE					-					or Town, Sta		-		
	e, M l and 2 Health item 2		20a. Method of Disposition	· ·		20	- DI	D1 14	(51	- 6			D-1-	00-1-	S MD	T	01-1-		Η.
	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Crem 4 Donation 5 Other		Removal fro	om State (	CARROL	Lor Ch	<b>EMA</b> T	ION	INC.	2/1	0/200	,   на	MPSTEA SON &	יו ח	ΜD		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se					22. Na					JOL 1	- FATIA	JUIT a	DIVO	۱ و ۱۰	INC.	
	Physician		23a. Part I. Enter the diseas	e or complicat	tions that ca	aused the de	ath Do not	enter the							PIKESV		E, ME		:08
	/Medical		failure. List only one co	use on each li	ine.	e injur			, mode on	iying, so	ion ao can	4140 01 1	copilatory a	11031, 31100	K, Of House		etween O Dea	nset and	
3	aminer		Immediate Cause (Final dis or condition resulting in dea			consequenc										$\dashv$			1
		er	Sequentially list conditions, if any, leading to immediate	b Due	to (or as a	consequenc	e of):									+			$\dashv$
	ì.A.	Examine	cause. Enter Underlying Ca (Disease or injury that initial	ed e		consequenc										4			_
	nd ransit		events resulting in death) L	ast Due d.	to (or as a	consequenc	e or):												
	<b>Sion of Vital Records, P.O. Box 68760,</b> Attending Physician: The law requires that the death certificate be executed readth.  readth.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit.	edical	X UNPENDED		MENDED	.28a-f.	perME.	e876	2/6/0	08 TT	1								
	376C ificate ig phys s the br		IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, o	outcome of p			al death		Ectopic p	reanan	5V		Date of deliv	ery	,	Year	
	Box 6876( te death certificate the attending phy ted for use as the b	sicia	past 12 months?	4		ant at time of	f death 5		er (Specif)	hum.	Lotopic p	regriant	·y	"	nortui	Day		r cui	
	D. Bc t the dea by the a ached fo	Physician/M	Part II. Other significant co	Unknown g			ot reculting i	n the un	dodvina	uso civ	on in Part	1	23a Did	tobaccous	se contribute	to the c	ause of d	eath?	4
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	β	. art in Other Significant oc	nations cor	itibuting to	death but in	or resulting i	ii iiie ui	derrying ca	iuse givi	enmran	•.	(1000)	170000	No 3 P				
	ords, w requir s been s should b	Completed											24a. Wa		24b. Were		findings		
	eco he law ate has	dwo												opsy formed? 2 No	death	?	2	_	
	Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to me examiner?						26.		f Death (C	heck on							
	F Vil	P	1 ✓ Yes 2 No	Hosp	' "	npatient 2	✓ ER/Outs			`			Home 5	Residen		her:			4
	on of \ nding Phy th. r: After the te funeral	ion	1 Natural 5	Pending	28a. Date ( (Month,		-		í I.		at Work? s 2 💢 N			in cehi	icle of	moto	r veh	icle	
	/isior r Attend ter death. virector: n by the	ficat		nvestigation Could not be		2/4/200 e of Injury - A			) Mild				ccident 8f. Location	(Street and	d Number or	Rural R	oute Num	ber, City	$\exists$
	Divisor Applied or App	Certification:	4 Homicide	determined	not be or Tow						OL 1695	own, State) 1995 Rte. 70 Baltimore, MD							
2)	Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 ☐ Certifyir (Check only one) 2 ✓ Medical	g Physicîan: Examiner:On		-	-										ıse(s)		
<i>\\</i>	To t with To t	Medical	29b. Signature and title of ce	and	manner st					icense r				_	ate signed (A				$\dashv$
đ	X		- handen	mi	JE-	C/ T	и			D.C.M.	.E.	OCI	ΛE	Dece	mber 5, 2	:007			
4	Sta	ŀ	30. Name and address of pe					N)											$\dashv$
	TY		Theodore M. King,			nt Medica		er 1	11 Pen	Stree	et, Balti	more,	MD 2120	)1					
	St Regist	ate rar	31. Date filed (Month, Day, Y	0 2007	32. <b>S</b> e	gistrar's Sigr	lature	ha	KI										
DH	IMH 17 Rev 1/2	001					ORIO	SINAL											_

			For State Registrar	State of Ma	fyland/Depa Cel	a <b>tific</b> ate of l			giene Reg. No⊃ ∩ (	מחכ דו	50	
Self			Decedent's Name (First, Middle, Last)	)				2. Date of Dea	ith C U	3. Time of D	eath	
ı	Physici /Medic		Dorothy K. Kree	k				Novembe		Year 007 11:25	$PM^{M}$	
	Examir		4a. Facility Name (If not institution, give				Location of Death	1	4c. County of			
			Charlestown Hea  5. Social Security Number 6. Se		(In yrs. last birthday)	Catons If Under 1 Year		8. Date of Birt	Balti		Foreign	
ŀ	Funeral Director		497-40-4182	]M 2∏F	94 Yrs.	Months Days	Hours Min.	(Month, Day May 26,	, Year)	9. Birthplace (State or I Country) Missouri		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City	Limits	
	Mary I-f sho fied a	tor	MD Baltimor	·e	Caton	sville				1 ☐ Yes 2	X No	
	th the or 28c e noti	Director	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·	10f. Zip Code			10g. Citizen of W	hat Country?		
	ath wi	ral	709 Maiden Choice				21228		USA			
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medic⊪l Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Endemoder Forces?  1 ☐ Yes 2 ☐ Wolf Yes, Give Year or Dates:	. !	Was Decedent of H If Yes, specify Cuba I □ Yes 2∏ No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black	- American Indian, k, White, etc. white		
5	72 hor	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)	ı (Give	dent's Usual Occup	during most of wor	king I	16b. Kind of Bus	siness/Industry		
121	within iene. than " he Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	) life. L	00 NOT use retired eacher	0		educat	ion		
<b>d</b> 2	Hygid other ent, the	Be Co	17. Father's Name (First, Middle, Last)		<b>L</b>	eacher	18. Mother's Nan	ne (First, Middle,	Maiden Surname			
/lan	2 should be and Mental is marked c	To B	Delbert Whitmore	Delbert Whitmore Flog								
Maryland 21215-0036	1 and 2 should Health and Men em 27 is marke other traumatic		19a. Informant's Name/Relationship (7) David Kreek/son	rpe. Print)		ng Address <i>(Street a</i> Ryans Ru				State, Zip Code) MD 21631		
Baltimore,	Pages 1 anent of Heanint; If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location - 0	City or Town, State		
Balti	permit. Page Department of Important; if any Injury of once.		21. Signature Juneral Service licens	Wade, Vire		Name and Address ate Anat			Baltimo	ore Street		
	Physician /Medical Examiner			Due to (or as a	Auteros	er the mode of dyin	g, such as cardiad <b>COTONAT</b>	or respiratory ar artery	disease	Approximate interval Base Office Constitution of the Constitution	een eath	
68760,	fficate be executed g physician and ss the burial-transit	edical Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0	consequence of):							
.O. Box	the death certify the attending iched for use as	ysician/Me	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown	Petal death 3 ☐	]Ectopic pregnancy ] Other (specify)	,		23d. Date Mor	e of delivery nth Day Ye	ear
О.	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to		ibute to the cause of dea 3 ☐ Probably 4 ☐ Un		
or Vital Records,	The ate has page	Completed							rmed? d	Vere autopsy findings av vrior to completion of cau leath? □Yes ☑ No	vailable use of	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only o	ne)			
	ing Phys After this uneral dir	on: To	1 Yes 2 No  27. Manner of eath 1 Natural 5 Pending	1 ☐ Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatien  28b. Time of Injury	28c. Injur Worl	y at k?		lence 6 Other			
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	Accident  3 Suicide 4 Homicide  investigation  Could not be determined	y - At home, farm, str (Specify)		Yes 2 □ No		tion (Street and Number or Rural Route Number, or Town, State)				
	ie Hospital 24 hours a ie Funeral I	Medical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best of iner: On the basis of and manner state	my knowledge, deatlexamination and/or in ed.	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier		- ^	29c. License	e number		29d. Date signed	(Month, Day, Year)		
•			monle	+	TO		19890		Deci	7005 10		
			30. Name and appress of person who co			Maiden	Chric	aln	arth	suille M	10	
	Sta Registr		31. Darevilled (Month, Day, Year)	2012 32 Registrar	's Signature	We was	CIVIC	- LII	- Culu	DAINE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:45 AM Evelyn Anna Dez Kirschke 07 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ST. AGNES HOSPITAL BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 X F 215-14-4766 Director January 16, 1923 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Director Baltimore Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Brandford items 23a Funeral 1209 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Typist 12 Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kirschke trederick Anna Muenzing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Brandford Rd Constance Davis Catorsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry December 7,2007 Hancver, MU 4. □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Gonelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY HYPERTENSION 5 years /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to for as a consequence offattending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No Renal 24a. Was an autopsy performed? Yes 2. No Division or Vital 1☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 T Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fil Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mallike A P22257 12 07 2007 900 S. CATON AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANGITIPALLI ST-AGNES HOSPITAL BALTIMORE MALLIKA 3 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 1 0 2007

			-	•	ryland / Depa		t of H	ealth a		ental Hyg	ien <del>g</del> ( eg. No.	07	39361	
9	Physici		Decedent's Name (First, Middle, Last)     MARY MARGARET KRO	NENBERG						2. Date of Dea December		7 Year	3. Time of Death 9:30A M	
	/Medic Examin	v	4a. Fecility Name (If not institution, give st. 246 Coldbrook Road	reet and number)		4b. City,		Location o	f Death			inty of Death timore		Ī
	Funeral Director		5. Social Security Number 6. Sex 1 □	M XX F 7. Age	(In yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 26, 1	920 920	Coun	lace (State or Foreign try) yland	_
	e-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore		10c. City, Town or Lo								0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	3a or 28	i Director	10e. Street and Number 246 Coldbrook Road			10f. Zip	Code 210	93		1		of What Cour	itry?	
Baitimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event, the Medical Evantist most be rediffical at	by Funeral		d 1 TVes XXXV		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes XXXX No Specify:			pecify Yes or No- o Rican, etc.)  14. Race - American Indi- Black, White, etc.  Specify: White			etc.		
	filed within 72 ho Hygiene. other than "naturent, tra Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)  (Give In the College (1-4or 5+)		dent's Usual Occupation kind of work done during most of workir. DO NOT use retired) leS			16b. Kind of Business/Indus			dustry		
land 2	id be filed ental Hyg ked other Ic event,	To Be C	17. Father's Name (First, Middle, Last) Michael Joseph Gillooly		,					(First, Middle, t Mary Ro		name)		
Mary	nd 2 should be Ith and Mental 17 is marked traumatic eve		19a. Informant's Name/Relationship (Typ Kaarin A Burton							al Route Numbe Maryland		wn, State, Zip	Code)	
ore,	Pages 1 and 3 nent of Health out: If item 27 iry or other tr		20a. Method of Disposition	moval from State	20b. Place of Disponentery, cre					Date		on - City or To		
Baltim	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other ti once.		4 (Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Dulaney Vall	•	d Addres	s of Facilit	Mitc	, 2007 hell-Wied wad Balti	lefeld l	Funeral	Home Inc	
760, ~	Physician /Medical Examiner	icai Examiner	23a. Part1. Enter the disease of complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, reading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):		nee						Interval Between Onset and Death	
.O. Box 68	The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the k	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 13 months? 1 ☐ Yes 12 No 9 ☐ Unknown	ic. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death 3	□Ectopic pi □ Other (sp					23d	Date of delive	ery Day Year	
Ф	uires thet the de n signed by the a lid be detached f	b	Part II. Other significant conditions con-	tributing to death b	ut not resulting in the	underlying o	cause giv	en in Part I		23e. Did to	_		he cause of death? pably 4 Dunknown	
of Vital Records,		Completed								24a. Was autop perfo 1 🗆 Yes	sy	4b. Were auto prior to co death? 1 \sum Yes	opsy findings available impletion of cause of	
Vita	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ent 2 ER/Outpatie	ent 3 DO	Oth Oth		= 1 - 1	me 5 Resid		Other (Speci	(y)	
ion of	fing After fune		27. Magner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da)	ry Year) 28b. Time (	of 2	28c. Injun Wor 1 🖂	yat k? Yes 2 🗆	No	28d. Describe I	now injury o	ccurred		
Division	ef or Attendi s after death of Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, s c. (Specify)	treet, factor	y, office			28f. Location (5 City or Tox		lumber or Rur	al Route Number,	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one) 2 Medical Exemination (Check only one) 2	ician: To the best er: On the basis of and manner sta		ith occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	red at the time,	date and pl	ace, and due t	o the cause(s)	
)	To the within To the comp	Me	29b. Signature and title of certifier	and in	W	29	c. Licens	309	29		121	igned (Month,		
	·h		30 Name and address of persony who co	D Car	pme	656	9/	U, C	hire	955	BA	to 1	DZROY	1
*	St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 1 0 200	AF .	ar's Signature	sells.							,	

State Registrar DHMH 17 Rev 1/2001

■ Baltimore, Maryland 21215-0036

	_ For	e Type or Prin State of Ma				. <b>Ensure A</b> llealth and M		_		
	1 - State Registrar			Cei	rtificate of	Death	R	eg. NS 117	39362	
an cal	1. Decedent's Name (First, Middle,	John R			Linthicum	n	2. Date of Dea Month	th Day Year	3. Time of Death 2:50 P M	
er	4a. Facility Name (If not institution, g	give street and number)			4b. City, Town, o	r Location of Death	Decemb	4c. County of De		
	3114 River Dri	ve Road			Edo	gemere		Baltin	more Co.	
	Social Security Number 6		e (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)   (	irthplace (State or Foreign Country)	
	216-13-7803	KE IVI ZUF	27	Yrs.			Sept. 1	6,1980	Maryland	
	Usual Residence of Decedent  10a, State 10b, County		10c, City	, Town or Lo	ocation				10d. Inside City Limits	
ō	Maryland Ba	ltimore				Edgem	ere		1 □Yes 2⊠No	
Funeral Director	10e. Street and Number				10f. Zip Code			log. Citizen of What (	Country?	
Ξ	3114 River Dr	ive Road				1219		United		
lera	11. Marital Status	12. Was Decedent B	Ever in U.S	S. 13.	Was Decedent of F	lispanic Origin? (Sp	ecify Yes or No-	14. Race - An		
	1 ☑ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 21☑ N	No			an, Mexican, Puerto	Rican, etc.)	Black, Wh	nite, etc.	
2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 25 No	Specify:		Specify:	White	
2	15. Decedent's (Specify only highest)	Education		16a. Dece	dent's Usual Occup	ation	ing	16b. Kind of Busines	s/Industry	
5	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT use retire	during most of work d)	,,,g			
Completed		1 Year		M	Musician			Enterta	inment	
ב	17. Father's Name (First, Middle, La	,				18. Mother's Name		Maiden Surname)		
2	John Edward L	inthicum					Carol	Yarbrough		
	19a. Informant's Name/Relationship Mrs. Carol Linth		•	1	-	and Number or Rur rive Road		r, City or Town, State ere, Maryl		
	20a. Method of Disposition 1 ☐ Burial 24 Cremation 3	☐Removal from State	C	emetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location - City of		
	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		Hi			corp. 12/		Towson, Dundalk,		
	de regan	E. Keen	L_		7922 Wis	se Ave. I	Dundalk,	Maryland		
	23a. Part1. Enter the disease or co shock, or head allum. List or Immediate Cause Final disease or condition	omplications that caused nly one cause on ear h lin	the death	n. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arı	est,	Approximate Interval Between Onset and Death	
	resulting in death)	Due t (or a a	a consequ	uence of):	O	J				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):									
enical		d								
Priysician/imedic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year	
2	Part II. Other significant conditions	s contributing to death bu	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown	
Completed							24a. Was a autop:	sy prior to med? death?		
O	25. Was case referred to medical					26. Place of Deat		2 <b>X</b> No 1 □ Ye	es 2 No	
n	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 1	ER/Outpatier	nt 3 DOA Oth		A	ence 6 □Other (Sp	necify)	
- 1	27. Manner of Death	28a. Date of Injur	ry	28b. Time o	f 28c. Injur	y at		ow injury occurred	1 1	
	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	ion RCDW De 4		14 50	Wor	k? Yes 2,☑No	Suice	I = I - I	langing	
Certification:	3 Suicide 6 ☐ Could not 4 ☐ Homicide determine	be Blace of inju	ıry - At ho	me, farm, str	eet, factory, office				Rural Route Number, Rd	
Calcal	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best of taminer: On the basis of and manner sta	f examinat	wledge, death tion and/or in	h occurred at the ti	me, date and place, opinion, death occur	and due to the o	ause(s) and manner date and place, and d	as stated	
Me de	29b. Signature and title of certifier	A THORNOI STO	1		29c. Licens	e number	2	9d. Date signed (Mo.	nth, Day, Year)	
	30 Name and address of pages with	W Dep	the of	2kg) /Time	Print)	dele 1		Decembe	15,2007	
	30. Name and address of person when the state of the stat	Registra	) (e	TVI	mble	H:11 CT.	Luthe	ru:lle,1	16 21093	
te ar		2007 Julye	- 6	& Con	well !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Day Month **Physician** Longenedel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 21 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ☐ M 2 🗓 F Canada 86 Yrs 216-40-6130 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count 1 ☐ Yes 2 X No MD Baltimore Parkville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8800 Walther Blvd. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 X No Specify: White Completed by 3 X Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Exectutive Secretary Applied Physics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental I Is marked Joseph Moore Elizabeth Turnock Benson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Longenecker-son 7250 Meadow Wood Way, Clarksville, MD 21029 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Serv Corp Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/8/07 Towson, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Leonard J. Ruck, Inc. Dau 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final debi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy signed by the atte Year Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) a∏tJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No I or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 30 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Burnen The du) Bruce 31. Date filed (Month, Day, Year)
DEC 1 0 32. Pojistrar's Signature State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM 17.18, per H . 8374.12/27/07 WS

State of Maryland / Department of Health and Mental Hygiene 39364 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** 1850 PM 02 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 F 96 Yrs. Director 169-34-0051 12-25-1910 Va. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Baltimore NA Md. 1 ▼Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 21239 1451 Kitmore Rd. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items ledical Examiner m 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo ģ Specify: Black 3 Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Martha William ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Clash Daughter 1451 Kitmore Rd., Baltimore, Md. Sattimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Cem. Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-11-07 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 00 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Year Dav signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perfor certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 27 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print 560 XOCK 32. F gistrar's Signature State Registrar

V

State of Maryland 156 partinent of Health and Mental Hygiene State Registrar Amend #25, perME,g875, 1/25/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician NOVEMBER 24, 2007 AVERY 8:10A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MANOR CARE PRINCE GEORGES LARGO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days 1 □ M **X**|X|F MAR. 26, 1936 NORTH CAROLINA Director 243 54 1025 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r 28a-f show notified at XIX Yes 2 No Director PRINCE GEORGES SPRINGDALE MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or a 20774 UNITED STATES Funeral 3507 TYROL DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XX No Specify: BLACK Completed by ¥₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT/ Elementary/Secondary (0-12) College (1-4or 5+) YRS. STATE DEPARTMENT ADMINISTRATIVE ASSISTANT ages 1 and 2 should be filed vent of Health and Mental Hygie nt: If item 27 is marked other ty or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta. Important: If them 27 is marked of any Injury or other traumatic every ဥ MARY SMITH JAMES AVERY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SPRINGDALE, MD 20774 JOSEPH A. LAMBERT, III / SON 3507 TYROL DRIVE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 12/01/2007 LANDOVER, MD 22. Name and Address of Facility

MARSHALL S FUNERAL HOME OF MARYLAND, 21. Signature of Funeral Service Licensee 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE MULTIPLE MYELOMA /Medical Due to (or as a consequence of) Examiner APLASTIC ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed SUBDURAL HEMATOMA burial-trai Due to (or as a consequence of) Physician/Medical CARDIOMYOPATHY IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1☐ Yes XX No
9☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SEVERE THROMBOCYTOPENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably ¥X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes XX No page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760 or Attending Physician:

24 hours after death Puneral Director;

within 2

State Registrar

Certification: To

5 ☐ Pending investigation

6 Could not be determined

MD

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D62116

home

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 35

Springasle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

1 🗌 Inpatient

November 11, 2007

28a. Date of Injury (Month, Day Year)

and manner stated.

NOVEMBER 27, 2007

MEKLIT WORKNEH, MD.

7705 BELLE POINT DR.

GREENBELT, MD 20770

Other: XX Nursing Home 5 Residence 6 Other (Specify)

Drive

28d. Describe how injury occurred at home

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1⊠ Yes XX

27. Manner of Death

Accident

4 ☐ Homicide

3 Suicide

29a. Certifier (Check only one)

XX Natural

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 1132 AM SUSALEE M. LENGAL REEMSER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST TOWSON If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 12/16/1930 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 💢 F Yrs. OHIO 298-24-8240 76 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE PARKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20229 YORK RD 21120 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAMONT MARSH EDNA MARY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA BAKER (DAUGHTER) LITTLE FALLS COURT PARKTON, MD. 21120. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State GREEN MOUNT CREMATORY12/11/07 BALTO. CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeyal Service License W. JENKINS & SONS C YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PULMONARY FIBROSIS MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown þ Completed Be ( Certification: To

be executed Division or Vital Records, P.O. Box 68760 After Hospital or Attending

burial-trar as the page 2 within 24 hours after death To the Funeral Director: the filled in by

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

within 72

d 2 should be filed w h and Mental Hygies 7 is marked other th

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, t

DIABLTES	tions contribu		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknow						
			-				24a. Was an autopsy performed? 1∐ Yes 2 ☑ ♂	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No	
25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No		26. Place of Death (Check only one)  dospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence & Other (Specify) HOSPICE							
27. Manner of Death  1 PNatural 5 □ Pend 2 □ Accident inves		a. Date of Injury (Month, Day Year)	28b. Time of Injury	vi	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		d. Describe how injury		
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	I not be mined 28	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	I Examiner:				d at the time, date and place on, in my opinion, death occ			and manner as stated. place, and due to the cause(s)	

12

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO 6565 N CHARLES ST. SHITE 209 BALTIMONE, MD 21204

29c. License number

D64395

29d. Date signed (Month, Day, Year)

DECEMBER 6,2007

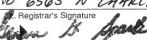
State Registrar

cal

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

DEC 1 0 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year ROBERT HALE LLOYD 2007 DEC. 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year JULY 20, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1**X** M 2□ F MARYLAND 80 Director 220-22-4615 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at WHITE HALL MD HARFORD 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5127 MEADOW VIEW DRIVE 21161 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must bence. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian Black, White, etc. 1 Never Married Married I XYes 2 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLANT DEPARTMENT TELEPHONE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SILAS PAUL LLOYD ERMA HALE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE LLOYD 5127 MEADOW VIEW DRIVE WHITE HALL, MD 21161 wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
FOREST RIDGE 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 12/7/2007 PARKTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of Funeral Servi 16924 YORK RD. MONKTON, MARYLAND 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNP 2 YEARS /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter United hing Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last g physician and as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has i autopsy performed? Yes 2 No 1 Yes or Attending Physician; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Souther (Specify) HOSPICE ို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Medical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide determined within 24 hours at To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

To the

0 Registrar

DANIEUE DOBERMAN MA State

29b. Signature and title of certifi

6565 N CHARLES ST, SUITE 209 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D64395

29d. Date signed (Month, Day, Year)

BACAMORE, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 39368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Anthony Louden November 23, 5:45 AM M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□F Hours Yrs. Director 219-52-6596 42 Nov 11, 1965 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2□No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4507 Whitfield Road 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No ģ 3 Widowed 4 Divorced Specify: black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Richey Hospice 828 Eutaw Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade State and Address of Facility and 655 W. Baltimore Street ann Baltimore, MD 21201 23a. P rt1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed lirector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 nown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1⊟ Yes Attending Physiclan: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Certification: To 1 Yes 17 1 Inpatient 2 ER/Outpatient 3 DOA After this 6 Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 L Natural 5 Pending investigation 2 Accident 1 Yes 2 No after death Director: filled in by ō 29 Medical

Division or Vital Records, P.O. Box 68760, 24 hours a Hospital within 24

3∐ Suicide 4 ☐ Hornicide	determined	28e. Place of injury - At home, fare building, etc. (Specify)	m, street, factory, office	28f. Location City of	on (Street and Number or Rural Route Number, r Town, State)	
29a. Certifier (Check only one)	1 Certifying Physi 2 Medical Examin	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date a lor investigation, in my opinion, de	nd place, and due to ath occurred at the t	the cause(s) and manner as stated.  ime, date and place, and due to the cause(s)	
29b. Signature and	title of certifier	Papul	29c. License number	12	29d. Date signed (Month, Day, Year)	
30. Name and addr	Witt	npleted cause of death (Item 23a) (T	type Print)	Rd Bo	2Hb, My 2/2/8	2
	DEC 1 0/201	SI Francis Di	7			_

State Registrar

07-09272
Harold Lee

2007 39369 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1700 hrs Medical Examiner November 30, 2007 Harold Lee 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 44 West Talbott Street 9. Birthplace (State or unk If Under 1 Year If Under 24Hrs Date of Birth (MM/DD/YYYY) 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Hours Director Nov 9, 1934 Country) 1 X M 73 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Ę 10a. State 10h County Y Yes 2 No 28a-f show Baltimore MD 72 hours after death with the Maryland irector 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 44 W. Talbott Street 21225 USA ۵ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married unk Yes Specify: white If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 the Medical permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk tant: If item 27 is marked or other traumatic event, i 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation 3 X Other Specify: in state 28 Nated Attato My Board 655 W. Baltimore Street 21. Sign ture of F al Service Licenses d. Baltimore, MD 21201 Approximate Interval rt I. Enter the distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** a un. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 3b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 V Unknown Completed r this certificate has been a al director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No Yes 2 V No 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: n 24 hours arter were he Funeral Director: A 1 V Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 1, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** James Vernon Myers December 5, 2007 9:07 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore City N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) | June 27,1928 9. Birthplace (State or Foreign Maryland 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Dundalk 10f. Zip Code 10g. Citizen of What Country? 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Maintenance Foreman Rec. & Parks 18. Mother's Name (First, Middle, Maiden Surname) Thelma V. Tegeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8528 Kavanagh Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ak Lawn Cemetery 12/10/2007 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Pm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death frute Jecus OBastune 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed 2 No 2 XN0 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3108 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No ZUU 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Catherine Myers December 5,2007 5:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middle River Baltimore Co. 3205 Iris Lane 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F 99 Director 212-10-5029 Nov. 7,1908 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or Items 23a or 28a-f shov the Medical Examiner πust be notified at 1 ☐ Yes 2 X No Middle" River Director Baltimore Maryland 10e. Street and Number 10t. Zip Code 10g. Citizen of What Country? 3205 Iris Lane 21220 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten
any or other traumatic event, the Medical Examiner. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. 3 Widowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 6 Years Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sturm Mary Sweeney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Iris Lane Middle River, Maryland Mary Saylor (Daughter) 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 12/10/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. INGULA 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1 Finter the disease, or complications the caused the death. Do not entry the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence ot) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and a The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 2 ER/Outpatient Certification: To 1 Inpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

ANE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Leonard J. Masijauskas 8:30 P M 3, December 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Eastpoint Nursing Home Baltimore Co. Eastpoint If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**X** M 219-12-6701 83 Pennsylvania Feb. 19,1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore Dundalk Maryland 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 21222 United States 885 Mildred Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Xes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2KKNo Specify. WWII 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Police Officer 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stella Onwidiute John Masijauskas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelina Masijauskas (Wife) 885 Mildred Ave. Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩Burial 2 Cremation 3 Removal from State Sacred Ht. of Mary Cem. 12/7/2007 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wre of Funeral Service Centre 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. ate Cause (Final MULARMYLASTE

**Physician** /Medical Examiner

Examiner

Physician/Medical

Completed by

Be ပ

Medical Certification:

31. Date filed (Month, Day, Year)

DEC 1 0

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

28a-f

23a or

"natural", or

permit. Pages 1 and 2 should be filled wit. Department of health and Mental Hyglen. Important: If Item 27 is marked other tha any injury or other traumatic event, the once.

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

with the Maryland

death Items

72 hours after

filed within ene.

Baltimore, Maryland 21215-0036

physician and T attending p ed by the a signed to peen cate has t certificate this

law requires that the death certificate be executed After th funeral Hospital or Attending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu the

Division or Vital Records, P.O. Box 68760

resulting in death)	a. 11110000	1-3							
resulting in death)	Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a consequence of):								
resulting in death) Last	Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		opic pregnancy er (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions of	contributing to death but not resulting in the underl	ying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Donknown					
			24a. Was an autopsy performed? 1  Yes 2						
25. Was case referred to medical examiner?	26. Place of Death   Check onl   one								
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 44 Nursing H	Home 5 ☐ Residence	6 ☐Other (Specify)					
27. Mann of Death  1 atural 5 Pending 2 Accident investigation		28c. Injury at Work?  1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)					
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi- and manner stated.	urred at the time, date and place gation, in my opinion, death occ	e, and due to the cause urred at the time, date a	r(s) and manner as stated. and place, and due to the cause(s)					
29b. Signatuje and title of certifier		29c. License number	29d. [	Date signed (Month, Day, Year)					
(100		1 007777	-	21/1/27					

State

Registrar

rom woods Road.

and address of person who completed cause of death (Item 23a) (Type, Print)

8813

Registrar's Signature

			For State Registrar	State of Ma	aryland		irtment of H tificate of L			giene Reg. Na	711117	39373
Physi	iciar	,	1. Decedent's Name (First, Middle,				·		2. Date of De Month	Da	y Year	3. Time of Death
/Med Exam		-	Anna B. Mara 4a. Facility Name (If not institution,	ihrens give street and number)			4b. City, Town, or	Location of Death	Decemb		, 2007 County of Deat	3:15 P <sup>M</sup>
Exali	IIIIe		Johns Hopkins B					ltimore			N/	
Funera Directo			220-09-5816	6. Sex 7. Ag 1 ☐ M 2 ☑ F	ge (In yrs. Ia 88	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year) 1919	9. Birt Co Man	hplace (State or Foreign untry) ~yland
yland Iow at		-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	eation					10d. Inside City Limits
e Mar 3a-f sh tiffied	Discosper	2	Maryland	N/A		Ba l	ltimore					1 X Yes 2 □ No
with th			10e. Street and Number	Wanua			10f. Zip Code	24244		10g. Cit	tizen of What Co	
death ms 23 must	To a control	2	3210 Wisteria A	12. Was Decedent	Ever in U.S	6. 13. V	Vas Decedent of Hi Yes, specify Cuba	21214 spanic Origin? (Sp	ecify Yes or No	)-	U.S./	rican Indian,
filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Ž	2	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 X  If Yes, Give  Year or Dates:			f Yes, specify Cuba □ Yes 2 <b>X</b> No	n, Mexican, Puerto	Rican, etc.)		Black, Whit	<sub>e, etc.</sub> hite
"natur	2000	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	ent's Usual Occup kind of work done o OO NOT use retired	ation furing most of work	ing	16b. K	(ind of Business/	Industry
withir liene. r than	8	5	Elementary/Secondary (0-12)	College (1-4or !	5+)		ance Cler			Ir	nsurance	Company
e filed al Hyg I other	0		17. Father's Name (First, Middle, La	ast)				18. Mother's Nam		, Maider	Surname)	
should be and Mental marked o	F	5	Morris H. Brown						e D. Ro			
id 2 sh lith and 27 is m traum			19a. Informant's Name/Relationship Mrs. Louise MacS		iond		g Address (Street a					,
is 1 and of Health item 27		-	20a. Method of Disposition		20b. Pla	ace of Dispos	Roland A sition (Name of natory or other place	ا ا	Date	20c. L	laryland ocation - City or	Town, State
Pages ment of H ant: If ite			1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Cemetery	12/0	3/2007	-		Maryland
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any Injury or other traumatic event, the Medical I	ouce"		21. Signature of Funeral Service Li	4		l	. Name and Addres Leonard J	. Ruck,	Inc.	Balt	Harford imore, I	d Road MD 21214
			23a. Part1. Enter the disease, of co shock, or heart failure. List or	omplications that caused nly one cause on each li	d the death. ine.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician /Medica			Immediate Cause (Final disease or condition resulting in death)	a. Dem	entia_							Onsertand Death
Examine				Due to (or as	a conseque	ence of):						>5415
P N.E	2	2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
xecute and	Evaminor	Yall	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
flicate be executed physician and and the burial-transit			- 1	d								
ertifical ing phy e as th		Medical	IF FEMALE:	T								
The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as	M/acioiav40	ysiciany	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other <i>(specify)</i>				23d. Date of de Month	ivery Day Year
res that the de signed by the a	9		Part II. Other significant condition	-		7	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
w require been sig			CAD. CHF. CVA	+. HTN. A.	trul	Fib			1 🗆	Yes 2	No 3∏Pi	robably 4 Unknown
The law cate has be page 2 sh	Completed								24a. Was auto perfo 1∐ Yes		death?	utopsy findings available completion of cause of 2 No
Physiclan: The this certificate Ir ral director, page	ď	ב	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	200	TD (Otti	Othe	26. Place of Deal				
g Physer this eral di	F	- 1	27. Manner of Death	28a. Date of Inju	ury	R/Outpatient 28b. Time of Injury	28c. Injur	4 Nursing Ho	ome 5 ∐ Res 28d. Describe		6 □Other (Spe	cify)
endin sath. or: Aff	1	allo	1  Natural 5  Pending 2  Accident investigat 3  Suicide 6  Could no	ation			M 1 🗆	Yes 2□No				
tal or Att s after de al Direct	Cortification		3 Suicide 6 Could no 4 Homicide determin	28e. Place of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre )	eet, factory, office		28f. Location ( City or To	Street a wn, Stat	nd Number or Ri e)	ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, it	) lealed			Physician: To the best examiner: On the basis of and manner st	of examinati							
To th withir To th comp	MA	I	29b. Signature and title of certifier				29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
<i>,</i> /	/		Fred K	1				560110		4	2/4/	7
5	)		30. Name and address of person w					Circle,	Balti	more	MD	21224
Regis	State stra	-	31. Date filed (Month, Day, Year)  DEC 1 0	2007 32/Registr	rar's Signati	u'e	Bayview				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHRESTDAN  $10:30 \text{ A}^{\text{M}}$ 1. December 6, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2020 Russell Avenue Baltimore Woodlawn 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 216-28-8098 75 July 2, 1932 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Directo Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2020 Russell Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Lega1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubert Philip Meyer Katherine Marie Eitemiller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Ann Meyer 2020 Russel Avenue; Woodlawn, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 12/8/2007 4 Donation 5 Other (Specify) Metro Crematory Catonsville, Maryland 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Euneral Sorvice 4 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONALE **Physician** COR disease or condition resulting in death) /Medical Examiner EMPHYSIZMA Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Division or Vital Records, P.O. Box 68760, < Due to (or as a consequence of) Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTBRY 1 Ves 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

OLO

DHMH 17 Rev 1/2001

29c. License number

#18,03 BCTEMORE

022114

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

39375 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician** SHIRLEY MAE MATHIAS DECEMBER 06, 2007 8:45AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2140 BROOKS DRIVE #504 PRINCE GEORGES FORESTVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2XXF Yrs 577 44 9026 73 05, 1934 WASHINGTON, DC Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If Item 27 ie marked other than "natural; or Items 23a or 28s-f ahow 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor the Medical Examinar must be notified at XXYes 2□No Director FORESTVILLE PRINCE GEORGES 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 2140 BROOKS DRIVE #504 20747 UNITED STATES Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give Race - American Indian, Black, White, etc. 1 ☐ Never Merried XX Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry FEDERAL GOVERNMENT / Elementary/Secondary (0-12) College (1-4or 5+) 4 YRS. SECRETARY DEPTARTMENT OF ARMY traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LLOYD BROOKS ALICE YANCEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is r other tra IRVIN MATHIAS / HUSBAND 2140 BROOKS DR. #504 FORESTVILLE, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State ortant: If i 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 12/12/07 SUITLAND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 nter the diseese, or complications that ceuse. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Pert Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical END STAGE DEMENTIA Examiner Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requiras that the deeth certificata be axecuted bunai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, igned by the ettending physician be datached for use es the buna use es the Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 27 No DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? ate has been s page 2 should TO Yes XXINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home S ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this within 24 hours efter deeth.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature end title of certifier A66665 ى) 07 NO CUD 7 6 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) DONA LESKUSKI, M.D. 9200 BASIL CT. #200 LARGO, MD 20772 31. Dete filed (Month, Day, Year) 32 Registrar's Signature State DEC 1 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death McLoughlin Eugene **Physician** December 8 2007 2007 12:20 pm - Eugene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 19, 9. Birthplace (State or Foreign Country) York Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F 85 Director 067-14-3317 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Baltimore 1 ☐ Yes 2 XNo Md. Director Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 26 Margate Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important; if Item ZZ is marked other than "natural", or iten may injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 s, Give r or Dates: 1 ☐ Yes 2 🛣 No Specify. Completed by White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Amaco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick McLoughlin Marv Gallagher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Grace McLoughlin/ Wife Lutherville, Md. 21093 26 Margate Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 12-10-07 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RUCK TOWSON FU 1050 York Rd. 21. Signature of Funeral Service Licens Funeral Home, d. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) velles /Medical Due to (or as a nsequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 1 Tyes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform 2 No director To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 | Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) 1 Natural within 24 hours after death.

To the Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25205 1041 who completed cause of death (Item 23a) (Type, Print) N. Chaules St. Betimer, MI 2120x 6701 6BmC 31. Date filed (Month, Day, Régistrar's Signature Year State DEC 1 0 Registrar 2007

			For State Registrar	State of Maryl		partment of I			giene Reg. No 20	07 3937	17
	Physici	an	1. Decedent's Name (First, Middle, La.	•				2. Date of De Month	eath Dav	3. Time of De	ath
	/Medic	cal	EARL 4a. Facility Name (If not institution, giv.	e street and number)		MISSLER 4b. City, Town, o	or Location of Dea	DECEMBE	4c. County	2007 08:00	AEM .
_	4 · 6 · 6 · 0 · 0 · 0 · 0 · 0 · 0 · 0 · 0		Saint Joseph	Medical C				vson		Baltimore	
	Funeral Director		5. Social Security Number 6. S 215-30-1375	ex 7. Age (In )  N 2□ F 81	yrs. last birthda Yrs	Months Days	If Under 24 Hr Hours Mir		ıy, Year)	Birthplace (State or Formula)  Country)  MD	oreign
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or	Location		122/0//2	.520	10d. Inside City L	imits
	e Mary ta-f sho tifled a	ctor	MD BALTIMOR	RE	ВА	LTIMORE				1 □Yes 2	No
	with the	Director	10e. Street and Number	2012		10f. Zip Code	_		10g. Citizen of	•	
	death	by Funeral	8418 STEVENSON  11. Marital Status	12. Was Decedent Ever in Armed Forces?	in U.S. 1	3. Was Decedent of H If Yes, specify Cub		Specify Yes or No	U.S. 14. Rad	ce - American Indian,	
36	rs after I", or Ite kamine		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 M Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:	no nican, etc.)	Specif.	ck, White, etc. y: WHITE	
2-00	72 hou natura lic E	eted !	15. Decedent's Ed (Specify only highest gra	lucation	16a. De	cedent's Usual Occup	pation	orking	16b. Kind of B	usiness/Industry	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medic   Examiner must be notifiled at	Completed	Elementary/Sacondary (0-12)	College (1-4or 5+)		ive kind of work done e. DO NOT use retire WNER	d)	Sharig	VENDI	NG MACHINES	
gug	be filed natal Hygie	To Be Co	17. Father's Name (First, Middle, Last)					ame (First, Middle,	, Maiden Surnar	/	
aryle	2 should be and Mental Is marked of aumatic even		CHARLES  19a. Informant's Name/Relationship (*)	Type. Print)	MISSI 19b. Ma	LER ailing Address <i>(Street</i>	BESSIE and Number or F		er, City or Town	BADDOCK State, Zip Code)	_
	and 2 lealth a m 27 is her trai		SYNDY GABER / DAU			5 DORLAND	DRIVE -				
altimore,	00	13	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  Decation 5 ☐ Other (Specification of the content of	Removal from State	BREW F	sposition (Name of trematory or other pla RIENDSHIP	<sup>ce)</sup> 12/	Date 07/2007	BALTIM	ORE, MD	
Balti	permit. Pag Department Important: I any Injury o		11. Signature of Funeral Service Licen			22. Name and Addre	ess of Facility	SOL LEVI	NSON &	BROS., INC.	
	V		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	leath. Do not	8900 REI enter the mode of dyin	STERSTON ng, such as cardia	N ROAD - ac or respiratory a	PIKESV	Approximate	
	Physician	2 74	Immediate Cause (Final disease or condition resulting in death)	9	D THO	RACIC AD	RTIC AN	IEURYSM		Interval Betwee Onset and Dea	th
	/Medical Examiner			Due to (or as a con-							
	<b>7</b> ₽ ₹	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sequentially list conditions, and are to conditions, and are to conditions of the co							
ン つ	rate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):						
8760,	ate be	dicat		⊾d							
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre					23d. Da	te of delivery	
o. E	requires that the death certific een signed by the attending p nould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□F 4□Pregnant at time ∈ 9□Unknown		3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	y 			23d. Date of delivery  Month Day Year	
7.	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions o	ontributing to death but not	resulting in the	underlying cause giv	ren in Part I.	23e. Did to	obacco use con	tribute to the cause of deat	h?
Records,	require een sig nould b	ted b	ARTERIOSCLEROTIC	CARDIOVASCU	LAR DI	SEASE		10	Yes 2X No	3 Probably 4 □Unk	nown
	has has	Completed	CHRONIC_OBSTRUCT	IVE PULMONAR	Y DISE	ASE			osy ormed?	Were autopsy findings avai prior to completion of cause death?	ilable e of
V Ital	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?					1□ Yes eath <i>(Check only o</i>		1 ☐ Yes 2 ☐ No	
<u></u>	hys his ldii	္ရ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	2 ER/Outpat	ient 3 DOA Oth	4   Nursing	Home 5 ☐ Resid	dence 6 Oth		
ion	ending ath. or: Afte he fune	ation	1 ★ Natural 5 Pending investigation			y Wor	k? Yes 2∐No	200. 00001100 1	now injury doods		
UIVISION	l or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Spe	t home, farm, ec <i>ify)</i>	street, factory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	per or Rural Route Number,	
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical C	(Check only 2 Medical Exam	ysician: To the best of my lainer: On the basis of exam	knowledge, de	eath occurred at the ti	me, date and place	ce, and due to the	cause(s) and m	anner as stated.	
	o the vithin 2	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signe	d (Month, Day, Year)	
			A. J. He	lou, M.D	7	D1	7695		Decem	ber 6,200°	7
	6		30. Name and address of person who						N 100 1		
8	Sta		31. Date filed (Month, Day, Year)	32. Recistrar's Si		and their fermi faces ( )	IVE TOW	ISON, MA	JRYLANI	21204	
	Registra	ar	UEC 1 0	2007	K	Snack o					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death
Month
Day 5
2007 **Physician** MILLER 0855AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KEIDTERSTOW NORTHWEST MEDICAL CENTUR SACTIMERE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-18-7520 1 M 2 F Director -10-1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at EISTERSTOUR 1 Tyes 2 TON Director MD 1SacrumoRE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21136 12020 KEISTERSTONN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 - N Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) UNKUUN NENOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Pages 1 and 2 should ပ クレストレンシノへ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath ar Important: If Item 27 Is any injury or other trau ROSLYN COOLEY PLOYER - WORKER 21204 611 Mis CENTRA. OBON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Surial 2 Cremation 3 Removal from State Mr. Commer Can DANTINGTE 4 ☐ Donation 5 ☐ Other (Specify) 12-10-07 Fu - VI erviçe Licensee 21. Signatur 22. Name and Address of Facility SKARDA FLUSTERE HOWE HUSSON ST DALTINGE 100113-0 2833 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disease Lonar **Physician** /Medical Due to (or as a consequence of) **Examiner** Athero Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) The 2003 and manner stated. 29b. Signature and title of certifier angen 054288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nolltiwest Holmas 31. Date filed (Month, Day, Year) DEC 1 0 2007 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** VERONICA MROZINSKI Year 4:00 AM DEC. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6307 EVERALL AVE BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗘 F Director 214-03-1796 95 10/16/1912 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 √ Yes 2 No Directo BALTIMORE N/A MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6307 EVERALL AVE 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN KRUSCZEWSKI UNKNOWN ZALESKI ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6307 EVERALL AVE STANLEY MROZINSKI-SON BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of Himportant: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) HOLY ROSARY 12/7/07 BALTIMORE, MD e of Juneral Service Licensee 21. Signatu 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR RD BALTIMORE, MD 21206 P1rt1. Exe the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final disease or condition resulting in death) Physician aus. /Medical Due to (or as a consequence of): Examiner man Salenter Vasaulen Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 3☐ No 24a. Was an autopsy performed? Yes 2 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT LIBERTO 3708 BANZ ST

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Registrar's Signature

07-09336 Van T Mauven

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

van i nguyen		1-For State State of Maryland / Department of H			. No. 200	7 2028
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)  The second seco		Date of Death Month December 2	200	8. Time of Death 1040 hrs
Ser.			City, Town, or Location of Death		4c. County of Death Baltimore Cou	
Funeral Director		645-36-3893 1X M 2 F 44 Yrs.	Under 1 Year If Under 24Hrs.  Months Days Hours Min.		(MM/DD/YYYY) 9. Bird Foreig 12,1963 Co	
and show any nce.	٥	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Texas:  Harris	Houston			10d. Inside City Limits  1 Yes 2 X No
with the Maryland s 23a or 28a-f show a c notified at once.	1 Director	4910 Saxon Drive #2	of, Zip Code 77092		g. Citizen of What Coul Vietnam	ntry?
er death v	by Funeral	1 X Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 X No	ecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto Ri s 2 X No specify:	can, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
36 in 72 hours s han "natura dical Exami	Completed b		Jsual Occupation (Give kind of wor of working life. DO NOT use retired		16b. Kind of Business/	,
215-00; be filed with ntal Hygiene, rked other the	Be Com	12 Years Nail 17. Father's Name (First, Middle, Last)  Chau Nguyen	Technician  18.Mother's Name (F  Thi Do		Cosmeto aiden Surname)	ology
MD 21 and 2 should alth and Mer em 27 is man		1	dress (Street and Number or Rui	ston, I	per, City or Town, State  TX 77092  20c. Location - City or	
Iltimore nit. Pages 1 a artment of He ortant: If it		1 Burial 2 X Cremation 3 Removal from State crematory or other 4 Donation 5 Other Specify: Hilltop Se			Towson, M	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	da-Ruck Funeral 22 Wise Ave. Du node of dying, such as cardiac or r	ndalk.	Maryland 2	Inc. 1 2 2 2 Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Cardingly with biventri Due to (or as a consequence of):	cular dilatation			Death
b	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
60, ate be executed hysician and the burial - transit	Medical Ex	d.  XUNPENDED  AMENDED  #23a,27,perME,g874, 12/13/	 ∩7 TT			
certific		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal (		;y	23d. Date of deliver Month	y Day Year
S, P.O. luires that the signed by taild be detached	ģ	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	1 Yes	2 No 3 Pro	bably 4 🗹 Unknown
Record The law rec	Completed			24a. Was a autops perforn 1 Yes 2	y prior to oned? death?	utopsy findings available completion of cause of es 2 No
/ital	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check on DOA Other'4 Nursing	· · ·	Residence 6 🗸 Othe	r: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  1a Director: After this certificate has been siled in by the funeral director, page 2 should the control of the funeral director.	一下	27. Manner of Death  1 v Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury (Month, Day,Year)	1 Yes 2 No		ow injury occurred	
Divisi Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct	l Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, find (Specify)		or Town, Sta	ate)	ural Route Number, City
To the Hospita within 24 hours To the Euneral completely fille	Medical	(Check only one) 2 Certifying Physician: 1 to the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.				
		29b. Signature and title of certifier	29c. License number O.C.M.E.		December 3, 20	
-6		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201			
Sta Registr	11.	31. Date filed (Month, Day, Year) DEC 1 0 2007  22. Registrar's Signature				
DHMH 17 Rev 1/20	01	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:40 P M Andrew Nozeika 3, December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Towson 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 60 April 27,1947 Director MD 218-44-7536 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director N/A Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I 21224 USA 3824 Foster Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married <sub>Specify:</sub> White 1 ☐ Yes 💹 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Armco Steel Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Corcoran Leo Nozeika 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3824 Foster Ave Baltimore, MD 21224 19a. Informant's Name/Relationship (Type. Print) Marlene Nozeika-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro 12/7/07 4 Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler and Son, Inc. 21. Signate Baltimore, MD 21224 6224 Eastern Ave Approximate Interval Between Onset and Death Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and it, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine cate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 X No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

Box 68760. Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 39382 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Catherine V. Overton DECEMBER 4, 2007 8:35P.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Reeders Memorial Nursing Center Boonsboro If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1□M 2₩F 215-09-5738 88 Feb 1 1919 MDUsual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Carrol1 Sykesville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5623 LaSalle Lane 21784 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ā Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Benson Margaret Weisiner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis C. Check (son) 5623 LaSalle Ln., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 12-7-07 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Paige Haight P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) teno schemotiz Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy

Examiner certificate be executed physician and s the burial-tran

Physician/Medical

þ

Completed

Be

Certification: To

Medical

29b. Signature and title of certifier

DR. VASANT DATTA, 31. Date filed (Month, Day, Year)

DEC 1 0

DU MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

MD

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Department of Health an Important: If item 27 Is any injury or other trauonce.

**Physician** /Medical

Baltimore, Maryland 21215-0036

ate has t page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O.

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year					
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Lokarown					
atroprovi	Alphianic Dinon	24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No					
25. Was case referred to medical examiner?	26. Place of Death (Ci	heck only one)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No	Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At nome, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)					
	ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.						

29c. License number

P1081 A

29d. Date signed (Month, Day, Year)

DEC5, 200)

301-739-7100

State Registrar

DHMH 17 Rev 1/2001

340 MILL STREET, HAGERSTOWN, MARYLAND 21740

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 9, **Physician** 10:14₩ 2007 Louis Puls /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Towson Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 15,1927 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F Director 217-20-2642 80 Maryland Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 TXYes 2 □ No N/A Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6917 East Baltimore Street 21224 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or iten
sny or other traumatic event, the Medical Examiner. 1**23**7es 2 □ No If Yes, Give Year or Dates:1945**-**58 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Aircraft Mechanic Aircraft Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Talbort John. A. Puls ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra Catherine P. Puls (Wife) 6917 East Baltimore Str. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Hilltop Service Corp. 12/12/2007 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1Qe Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi-Examiner be executed METASTATIC COLON CANCER sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate I 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 은 1 X Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 X Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. W 29b. Signature and title of-certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE. TOWSON, MARYLAND 21204 INTHICUM. M. D. . RICHARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 0 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da Year **Physician** :28 PM MENDLEton 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9885 Greenbelt Rd -anham Date of Birth (Month, Day, 3/25 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number **Funeral** Months Days Hours 1 □ M 21 F Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent, Ire Madical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1885 Green bel U.S.A 070b by Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.1 Dep\_Irment of Health and Mental Hygiene. Impurtant: If item 27 is marked other than "natt any injury or other traumatic avent, Ire Medica 2006. College (1-4or 5+) Elementary/Secondary (0-12) 12Yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNK ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code) Pendleton 4319 Kinmount Rd anham MD 20106 Kimberly 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Brentwood MD 4 ☐ Donation 5 ☐ Other (Specify) 814 upshor St NW 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Washinston DC. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, nmediate Cause (Final Inmediate Cause (r disease or condition resulting in death) Envsician 2014 /Medical **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e to (or as a consequence of) burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 🗆 No 1 ☐ Yes 1 🗌 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d, Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number a

DHMH 17 Rev 1/2001

Q

State Registrar 31. Date filed (Month, Day, Year)

impleted cause of death (Item 23a) (Type, Print

32 egistrar's Signature

un 95VU

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year William W. Phelps 172 CEMBER 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death ALUMDEL ARUNDEL MEDICAL ANNAPOLIS MALYLAND CENTER ANNE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 XM 2 □ F 263-40-3059 81 Washington, DC May 19, 1926 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Delaware Sussex Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19958 USA 32589 Fox Run 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc.

1 ☐ Yes 2 🛣 No

16a. Decedent's Usual Occupation

3 Ectopic pregnancy

3□ DOA

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

medical Parhuay, Amapolis, md

29c. License number

D56658

Injury at Work?

1 ☐ Yes 2 ☐ No

5 ☐ Other (specify)

Pilot

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

and

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

if yes, outcome pf pregnancy 1□Live birth 2□ Fetal death

4□Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

Specify: White

16b. Kind of Business/Industry

United Airlines

20c. Location - City or Town, State

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10416

29d. Date signed (Month, Day, Year)

DECEMBER 6, 2007

1 Tes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♠ No

Approximate Interval Between Onset and Death

Year

18. Mother's Name (First, Middle, Maiden Surname)

22. Name and Address of Facility Robert E. Evans Funeral Home

24a. Was an autopsy performed

2 No

28d. Describe how injury occurred

1∐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Grace Dufour

351 Derbyshire Lane Rive, MD 21140

20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Trinity
Episcopal Cemetery 12/14/2007 Bowie, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16000 Annapolis Road Bowie, MD 20715

1 XYes 2 No If Yes, Give Year or Dates 1943 – 1946

College (1-4or 5+)

Head

Physician /Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

items 23a or 2 iner must be n

r than "natural", or items 23a the Medical Examiner must

Director

Funeral

ģ

Completed

Be မ 1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

John Phelps

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 Could not be determined

ABRAHAM

DEC 1 0 2007

1 Tes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Shirley J. Cooper/ Sister

AL P. Knex

1 X Buriał 2 ☐ Cremation 3 ☐ Removal from State

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

State

Registrar

IF FEMALE:

attending physician for use as the buria as the l the detached director, page 2 should this certificate

Hospital or Attending after death Director: filled in by the To the Hospital within 24 hours at To the Funeral L sompletely

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

KX1

State of Maryland / Department of Health and Mental Hygier ( ) 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Oate of Death 3. Time of Death Month Year **Physician** 06:16 AM **FLORENCE** POLAN 2007 December /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore City

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. N/A 8. Date of Birth 09/24/1920 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F 218-07-9817 87 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7219 PARK HEIGHTS AVENUE, APT. #101 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No WHITE Specify þ 3 X Widowed 4 □ Divorced is marked other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H MAX KRAWITZ LENA LEWIS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 is any injury or other trau SUSAN C. POLAN / DAUGHTER 75 RAISIN TREE CIRCLE, BALTIMORE, MD 20b. Place of Disposition (Name of ARL ARUNO CONG. ARLANDO CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 12/07/2007 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or 4 a consequence of): Day /Medical Examiner Annair Brash Injun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) transit and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 1 Tyes 2 RONO Hype-tersion Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: or Attanding Injury 1 Natural 5 Pending To the need after death.

To the Funeral Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number December 5 2007 ILE3-az 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Jennifor Durphy, MD 31. Date filed (Month, Day, Year) 32. Palistrar's Signature Registrar 2007

とんでいます

Florence

21215-0036

Baltimore, Maryland

Division of Vital Records, P.O.

Patient

	1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygien	
Physician /Medical	same	POPP	4.00 7	December	
Funeral Director	Forest Have 5. Social Security Number 6.5	n Nursing Ho	t birthday) If Under 1 Year If Under 24 F	lle 1	9. Birthplace (State or Foreign Country)
with the Maryland a or 28a-1 show be notified at	10a. State 10b. County		own or Location  YTON), V. L.E.  101. Zip Code	100.0	10d. Inside City Limits 1 ☐ Yes 2 ☐ Ho  Citizen of What Country?
er death villams 23s	11. Marital Status  1 Dever Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 — The Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - American Indian, Black, White, etc.  Specify: () + 17
Maryland 21215-0036 of 2 should be filed within 72 hours alt in and Mantal Hyglene.  77 is marked other than "natural", or traumatic event, the Madical Examitation of To Be Completed by F		ducation 1	6a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	vorking	Kind of Business/Industry
Taryland 212 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ITEM TO Be Comp	17. Father's Name (First, Middle, Lest	950	18. Mother's N	Rum I Route Number City	
or Heal	20a. Method of Disposition  1 Burial 2 Cremation 3	z. Extraster 20b. Place	e of Disposition (Name of etery, crematory or other place)	ST. Brus	Location - City or Town, State
Baltimore, permit. Pages 1 at Department of Hee Important: If item any injury or othe	4 □ Donation 5 □ Other (Specification of the Service Licer	nt,	22. Name and Address of Facility	skaran Fu	one, MD 21224
Physician /Medical	25 art1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. End cause on each line.  a		Jesus	Approximate Interval Batween Onset and Death
60% be executed be executed burial-transit Examiner		b. Due to (or as a consequence.  Due to (or as a consequence.	ce of):		
the death certificate by the attending physiched for use as the systical and Medical physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
S, es t es t be c	Fait II. Other significant conditions of	entributing to death but not resulting	g in the underlying cause given in Part I.		use contribute to the cause of death?
	25. Was case referred to medical	E	36 Place of D	24a. Was an autopsy performed?  1 Yes 2 See eath (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?  o 1 Yes 2 No
Phy Phy ral d	examiner? 1 ☐ Yes 2 ☑ No	28a. Date of Injury (Month, Day Year)	- Other	Home 5 Residence 28d. Describe how inju	
Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral Medical Certification;		building, etc. (Specify)		City or Town, Star	,
To the Hospita within 24 hours To the Funeral completely filled	(Check only one)  2 Medicel Exemose)  29b. Signature and tire of certifier	iner: On the basis of examination and manner stated.	dge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc 29c. License number	curred at the time, date an	s) and manner as stated.  Ind place, and due to the cause(s)  ate signed (Month, Day, Year)
	30. Nagreyand address of person who of	ompleted cause of death (Item 23a	D/5876	2 Dece	mbe, 2, 200)
State Registrar	31. Date filed (NEC 2) 200	7 Se Registrar's Signature	Aprile 1	sty, and	ry LILO

The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To

WALTER POTRZUSKI

resulting in death)	Due to (or as a consequence of):									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.									
resulting in death) Last										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy or (specify)		23d. Date of delivery Month Day Year						
Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?						
		2 No 3 Probably 4XJUnknown								
			24a. Was an autopsy performed 1 Yes 2 🛣							
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)							
1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [	□ DOA Other: 4 □ Nursing H	ome 5 Residence	6X Other (Specify) HOSPICE						
27. Manner of Death  1  Natural 5 □ Pending 2 □ Accident investigation	I	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	nysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated.									
29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)						
		D63721		12/6/07						

4:10A.M

Birthplace (State or Foreign Country)

Black, White, etc.

White

(unk)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

State Registrar

10

DHMH 17 Rev 1/2001

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygie () 17 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 67 2007 12:35 AM /Medical Marie М. Robinson 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Haven Nursing Home Baltimore If Under 1 Year if Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 M 2 X Director <u>219-30-6876</u> 01/12/1925 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, inside City Limits nam 27 is markad other than "natural", or itams 23a or 28e-1 shov other traumatic event. The Medical Examiner must be modified at 1X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Penhurst Avenue U.S.A. 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black 3 XWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Coilege (1-4or 5+) Elementary/Secondary (0-12) Unknown Housekeeper Domestic d 2 should be filed with and Mental Hygier 7 is markad other the 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ages 1 and 2 should be not of Health and Menta : if itam 27 is marked ပ Isaac Smith Georgia Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Smith / Rep. Payee 3405 Avondale Avenue, Paltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/15/2007 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Sture of Funeral Savice Licens 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac . anythemlas 15 minus disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 104-5 heart disease theresclorenc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed 10425 ty portansian that initiated events resulting in death) Last burial-Due to (er as a consequence of): Box 68760. 1045 Diaheres mellitus Physician/Medical The law requires that the death certificate the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Jemenha periphonel arienal diseaue 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed? 2 No 1 ☐ Yes 2 12 No 1 ☐ Yes Hospital or Attanding Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fi 2 Accident investigation 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D30494 12/10/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idensville MOZIKE 710 maiden Chaice laine KOETHIM . Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 0 2007 Registrar

07-09265

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Willie Rawlings Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day Year November 30, 2007 Physician/ 1245 hrs Rawlings Willie Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 4016 Southern Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Social Security Number Foreign Country) **Funeral** Min Days Months Hours 216-56-8543 4-15-1950 Va. Director 57 1 XM Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No Baltimore NA or items 23a or 28a-f show must be notified at once. Md. Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10g. Citizen of What Country? Director 10f Zip Code 10e. Street and Number TISA 21206 4016 Southern Ave. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 XMarried 2 X No Yes Specify: Black Yes 2 X No specify: Divorced If Yes, Give Year 3 Widowed 16b. Kind of Business/Industry ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Flementary/Secondary (0-12) Baltimore City event, the Medical Demolitian Public Works MD 21215-0036 NA 12th grade of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rawlings Helen Viola Rawlings, Sr. C. Willie Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Saretha Kawling 4016 Southern Ave., Baltimore, Md. Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, I permit. Pages 1 and crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12-7-07 Lansdowne, Md. Mt. Zion Cem. Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility March F.H. East 21. Signature of Funeral Service Licensee 1101 E. North Ave., Baltimore, Md. 21202 la die Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and ysician failure. List only one cause on each line. Death ledical Narcotic and cocaine intoxication Immediate Cause (Final disease xaminer\_ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical tending physician a X UNPENDED perME.G874. 12/24/07 TT 28a-f. 23d. Date of delivery 68760 Year 23b. Was decedent pregnant in the Fetal death Ectopic pregnancy Live birth signed by the attending be detached for use as t past 12 months' Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 V Unknown ð 24b. Were autopsy findings available Completed 24a. Was an Records. page 2 should prior to completion of cause of been autopsy performed? death? has 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Nursing Home 5 Residence 6 V Other: Scene Hospital: 1 examiner? DOA ER/Outpatient 3 Inpatient 2 this ပ 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death After Certification: 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: Avecompletely filled in by the fun 1 Natural Pending 11/30/2007 lunk 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 4018 Southern Ave. Baltimore, MD 3 Suicide home Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number gnature and title of certifi 29b. December 1, 2007 O.C.M.E. Me whe Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Reistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Physici /Medic Examin

**Funeral** Director

/Medic Examin	once.	in al		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	any injury or other traumatic event, the	me	completely filled in by the funeral director, page 2 should be detached for use as the burial	5
/Me Exa	Important; if item 27 is marked other th	mı	To the Funeral Director: After this certificate has been signed by the attending physician	1
E)	Department of Health and Mental Hygier	(a	within 24 hours after death.	
	permit. Pages 1 and 2 should be filed wi	E	To the Hospital or Attending Physician: The law requires that the death certificate be ex	
	Baltimore, Maryland 21		Division or Vital Records, P.O. Box 68760,	,

	T = For State Registrar	State of Maryland		rtificate of		, ,	eg. No.			
	1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	th Day Year	3. Time of Death		
ı I	Elizabeth W. Reyr						er 5, 2007	8:09 A <sup>M</sup>		
r	4a. Facility Name (If not institution, give st	,		4b. City, Town, o	Location of Death		4c. County of Death			
	Greater Baltimore  5. Social Security Number 6. Sex	Medical Cent		Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimore	(0)		
	437-14-2214  Usual Residence of Decedent	6, 1920	place (State or Foreign htry) LA							
	10a. State 10b. County	10c. City,	Town or Lo	cation			1.	10d. Inside City Limits		
	MD Baltimore	a Baj	ltimor	.e			i	1 ☐ Yes 2 X No		
	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?		
	12 Knoll Ridge Cour	ct.		21210			USA			
		Was Decedent Ever in U.S Armed Forces?	3. 13.		ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Americ			
	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	rioan, etc.)	Black, White, etc.  Specify: White			
	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work ()	ing	16b. Kind of Business/In	dustry		
	12	College (1-40f 5+)	Ho	memaker			lwn Home			
ı	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Surname)			
١	George Michael Tro	oupe Wayne		i	Helen	Lillian	Luther			
	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Number	, City or Town, State, Zip	Code)		
	Richard W. Reynaud	d (son)	3359	Indian Sp	oring Roa	d, Mecha	nicsville,	MD 18934		
	20a. Method of Disposition	1 00	ace of Dispo	sition (Name of matory or other plac	ee)	Date	20c. Location - City or To	own, State		
	1 X Gurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	-		tery 12/1	3/2007	Arlington,	VA		
1	21. Signature of Peneral Service II censes	9					Funeral Ho			
ĺ	Taul Water	àu_	200		Road, To					
1	23a. Part1. Enter the disease, or comples shock, or heart failure. List only one	ations that caused the death.	Do not ent	er the mode of dyir	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between		
I	Immediate Cause (Final disease or condition	Carola		crest			1	Onset and Death		
ı	resulting in death)	Due to (or as a conseque		1700						
ı										
ı	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					-		
ĺ	that initiated events						*			
	resulting in death) Last	Due to (or as a conseque	ence of):							
	d.									
1	IE EEMALE:									
	FFEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown   23d. Date of death   3 □ Ectopic pregnancy   23d. Date of death   3 □ Ectopic pregnancy   4 □ Pregnant at time of death   5 □ Other (specify)   9 □ Unknown   9 □ U									
ĺ	Part II. Other significant conditions cont	ributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute to t	he cause of death?		
	atral tim	lation, ovar	lar !	Tunar		1 □ Ye	es 2∏ No 3∏ Prol	pably 4 □Unknown		
İ	of low mal	119 nont rotent	al -1,	regulal 5	0/4/6/4	ppsy findings available				
						autops	prior to co ned? death?	mpletion of cause of		
1	25. Was case referred to medical				26. Place of Death		2. No l 1 □Yes	2 No		
	examiner?	ospital:	R/Outpatien	t 3 DOA Oth	ar.		ence 6 □Other (Specia	(v)		
ŀ	27. Manner of Death	28a. Date of Injury 2	28b. Time of				ow injury occurred	97		
	27. Manne of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28b. Injury at Work?  1 Yes 2 No									
l	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number,							
l		n, State)								
	29a. Certifier  (Check only one)  (Check only on									
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Monitor)									
-	30. Name and address of person who com	impleted cause of death (Item 2	23a) (Type, i	Charles S	t. #5105	764	son, MD ?	21204		
ľ	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	1-0-						
	DEC 1 0 20	007 January	OF P	THE PARTY						

Registra

			For State Registrar	State of Maryland		rtment of F			giene	7 39392
All and a second	Physici /Medic	al	Decedent's Name (First, Middle, Last)     Aa. Facility Name (If not institution, give s	Joseph treat and number)	5-	eww.	r Location of Dea	2. Date of Dea Month Decem	Day	Year 3. Time of Death 2007 3: 16 M
	Examin Funeral Director	ier	5. Social Security Number 6. Sex 120-07-0728	M 2 F 7. Age (17.7 s. 1	last birthday).	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	move	N	N/A  9. Birthplace (State or Foreign Mary Tand
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A	10c. City	, Town or Loc	ation Itimore				10d. Inside City Limits 1 Yes 2 No
	3a or 28a-	Funeral Director	10e. Street and Number 3300 Benson Avenu	ue Unit 212		10f. Zip Code 212	227		10g. Citizen of W	
980	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, it is Madical Expirient must be notified at		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □ Yes 2 No		Specify Yes or No rto Rican, etc.)	- 14. Race Black Specify	a-American Indian, k. White, etc. White
21215-0036	d within 72 ho giene. er than "natur r to Modical"	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	(Give I life. D	ent's Usual Docup kind of work done DO NOT use retired Fighter	during most of wo d)	orking	Baltimor Fire De	re City
73	ould be filed Mental Hygir arked other attic event, II	To Be (	17. Father's Name (First, Middle, Last)  John Stewart					ame (First, Middle, nette Maz		θ)
Mary	and 2 should lead that and Men n 27 is marke		19a. Informant's Name/Relationship (Type Steven P. Stewart	·		g Address (Street 8 Jumper		Rural Route Numbe Baltin	or, City or Town,	State, Zip Code) 21236
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other tu		20a. Method of Disposition  1   □ Burial 2 □ Cremation 3 □ Real a □ Donation 5 □ Other (Specify)	1 0	omotoni cian	sition (Name of patory or other place eart of J	lesus 12,		Dundal	City or Town, State  k, Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signatura Funeral Service Dicense	. //		Name and Addre				ord Road , MD 21214
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e eause on each line.	heur	n 0 N I A	ng, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death  Z iv-elcs
	Examiner	er	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	D.	eme	ntia				years
8760,	icate be executed physician and $\frac{2}{\lambda}$ s the burial-transit	ai Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
9	ntificate Ing physical	Medicai	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed as been signed by the attending physician and a sage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	у		23d. Dat Mo	te of delivery nth Day Year
	quires that the de in signed by the a uld be detached t	þ	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.		obacco use cont Yes 2 □ No	nbute to the cause of death?  3 Probably 4 Dunknown
Records,	The law requir ate has been si bage 2 should	Completed	Dysphagia						psy prm <sub>e</sub> d?	Were autopsy findings available prior to completion of cause of death?
Vital	Physician: The rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			1 /	eath Check only	one	
of	ding Phys	tion: To	1 Yes 2 X No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injul Wo	4 Nursing	Home 5 Resi	dence 6 Oth	
Division	or Attending after death. Director: Afte in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location ( City or To		per or Rural Route Number,
7	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	Mins		29c. Licens	se number (-3 9 1	7	29d. Date signed December	d (Month, Day, Year)
	5		30. Name and address of person who co	mpleted cause of death (Item	п 23а) (Туре,	Print) Print)	. 15al-	timore	A .	vlomd 21227
	Sta Regist		31. Date filed Month, Day, Year) DEC 1 0 200	32 Registrar's Signa	ture	als?	1.10-1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NoZ U U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:32AM ouse 07 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours 213-28-6828 Director 1927 N.C Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show notified at MD N/A Baltimore 1 Nes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ō pe items 23a 2573 Kirk Avenue Funeral 21218 USA 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify þ 3 N Widowed 4 □ Divorced Black the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. 12th Johns Hopkins Hospital Dietary

18. Mother's Name (First, Middle, Maiden Surname) N/A 17. Father's Name (First, Middle, Last) Be ပ Walter Smith <u>Rosie</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Royster-daughter 16 Sparrow Hill Ct. Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 12/12/2007 Randallstown MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee H lady MARCH FUNERAL HOME-EAST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician lung cano /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 s autopsy performed? Yes 2 No page certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ORIGINAL

St. Paul

32. egistrar's Signature

301

2007

lau

DEC 1 0

wainer

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sanders December 4c. County of Death ertrude /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner NIA Bultimore Baltrmore 8. Date of Birth (Manth, Day, Year) Hos inai If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 □ M 2 F MD 216-30.2212 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 Yes 2 □ No Baltimore MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or edical Examiner must be 21209 Yellow wood Ave., Apt. 701 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Black Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kosewood State Hospital nstructor permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other tha any Injury or other traumatic event, the Aonee. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Dangerfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Sanders, Jr. 633 Commallis Road Teacher NC 28464 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Windsor Mill, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Kina Memorial Park 1210 2007 22. Name and Address of Facility Vangun (Greene Fundral 21. Signature of Funeral Service License 8728 Liberty Road Randallstown MD 21133 augun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardial Days **Physician** Nyo /Medical Due to (or as a consequence of): Examiner Heart herosa lerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed Mide Miy per Li Due to (or as a consequence of): burial Box 68760, physician EUSTON Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No Aneurys M certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? After t Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and use to the cause(s) and maintained as a substitution and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 son who completed cause of death (Item 23a) (Type, Print) Hospital 32. Renistrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 0 200 Registrar

		State of Maryland / Department of Health and Mental Hygiene
	_	1 - State Registrar Certificate of Death Reg. No. 2007 39393
Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 10:46 PM
/Medic	cal	Lawrence Alexander Shelton, Jr. December 1 2007 10:46 pm  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Examin	ier	SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY NAME OF BALTIMORE CITY
Funeral	i.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Pay Year) 9. Birthplace (State or Foreign (Month Pay Year))
Director		214-40-6538 116 M 2 F 67 Yrs. Months Days Hours Min. (Month, Day, Year) 5/10/1940 Country)
and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryla f sho ied at	ō	MD Baltimore Owings Mills 10 Yes 21 No
r 28a- notif	irec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
th witi 23a o ist be	a D	222 Mid-Pines Ct. Apt. 18 21117 USA
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene, is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", are items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
s afte	by Fi	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Specify: Specify: Specify:
2 hour	ed it	15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
thin 73 e. an "n Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)
ed wil ygien ier th	S	17 Father's Name (First, Middle, Jast)  18. Mother's Name (First, Middle, Maiden Surname)
be fill ntal H	Be	17. Father's Name (First, Middle, Last)  Lawrence, A. Shelton, Sr. Minnie Minus
hould Id Me mark matic	2	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
nd 2 s lith ar 27 is r trau		Elsie Shelton/Wife 222 Mid-Pines Ct. Apt. 18 DWMGSHills, MOZIIIT
is 1 and of Health item 27 other tr		20a. Method of Disposition  20b. Place of Disposition (Name of Competency or other place)  20c. Location - City of Town, State
Pages nent of I ant: If ite ury or o		4 Donation 5 Other (Specify) King Park 12/8/07 Windsor Mill, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at anone.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Juneral StvCs.
205 20		23a Part Flore the disease or complications that caused the death. Do not enter the mode of diving such as cardiac or respiratory arrest.  Approximate
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line.  Immediate Cause (Final
Physician /Medical		disease or condition resulting in death)  a. HPCT   12 days  Due to (or as a consequence of):
Examiner		RECUPERAT SOPSIS 5 moths
T 11/4	ner	Sequentially list conditions, If my realing to minute the consequence of the cause. Enter Underlying
icate be executed physician a	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
be ex ician a burial	E E	Due to (or as a consequence of).
ficate phys s the	edical	d.
n certi	M/u	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery
w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Year
at the	Phys	9 Li Unknown
ires th signed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
requ been should	etec	
he lav e has ige 2 :	Completed	autopsy performed? performed? performed?
an; T tificate tor, pa		1 ☐ Yes 2 ØNo 1 ☐ Yes 2 ØNo 25. Was case referred to medical 26. Place of Death Check only one
nysici nis cer direc	To Be	examiner?  1   Yes 2   No
ng Pt After th Ineral		27. Manner of Death  28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred
teath. tor: A	cati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Coulombed 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
l or Atlanter of Direct Direct In by	Certification:	4 Homicide determined determined building, etc. (Specify)
spital nours neral y filled		29a. Certifier 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hospital or Attending Physician; The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To t To t	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
1		RES-000 December, 1, 2007
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SRIRATNA · KONERU , MBBS SINAI HOSPITAL OF BALTIMORE
Sta	ate	31. Date filed (Month, Day, Year)  32 Aegistrar's Signature
Registi		DEC 1 0 2007 Annual States States

			For State Registrar	State of M	laryland	•	artment of H		and Mental Hy	giene	\ \ \ \ \ \	393	96
			Decedent's Name (First, Middle, Landson L	ast)			timouto or i		2. Date of De	ath		3. Time of	Death
	Physici		Helen M.  4a. Facility Name (If not institution, give street and number)		Szczybor Decemb					c 6, 2007 6:35			
	/Medio Examir				·)	520.	-	b. City, Town, or Location of Death			4c. County of Death		
	LXdiiii		Riverview nursing Home				Essex			E	Baltimore		
	Funeral				ge (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under	24 Hrs. 8. Date of Bi	rth	9. Birt	hplace (State or	Foreign
	Director		214-05-3381	1 ☐ M 2 <b>X</b> F	87	Yrs.	Mortus Days	Hours	February	4, 1		yland	
	pu >		Usual Residence of Decedent  10a, State 10b, County		100 City	Town or Lo	cation					10d. Inside Cit	h, Limits
	shov	2		more	Too. Oity,							1 🗆 Yes	•
	28a-f	Director	Maryland Balti  10e. Street and Number	HOLE		Car	10f. Zip Code			100 Citi	zen of What Co		
	with a or	급		Mar			2123	2.4			JSA	outry:	
	eath	Funeral	9307 Shady Creek 11. Marital Status	12. Was Deceden	t Ever in U.S.	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-					14. Race - Ame	rican Indian,	
<b>.</b>	iter d	F	1 ☐ Never Married 2 ☐ Married	Armed Forces	?		f Yes, specify Cuba	an, Mexican	, Puerto Rican, etc.)		Black, Whit	e, etc.	
936	urs a	by	3√□ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	-		1□Yes 21XNo	Specify:			Specify: W	nite	
21215-0036	i within 72 hours after death with the Maryland ilene. r than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at the Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gi	Education			dent's Usual Occup		of working	16b. Kii	nd of Business	Industry	
21	thin 'e	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d)	or working				
21	77 70	Co	12 years			]	Riveter			_	nn L. Ma	artin	
nd	9 H B S	Be	17. Father's Name (First, Middle, Las	t)					r's Name (First, Middle		Sumame)		
Z	should be and Mental marked c	ဥ	Frank Malinowski						hviga Gral		T	7 - 0 - 1 - )	
Maryland	~ (C w m		19a. Informant's Name/Relationship Anthony Leo Szczy		son		•		or or Rural Route Numb Jay, Carney			21234	
_	2 20 2		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of	-	December		cation - City or		
no	ages ant of t: If if		1 X Burial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec				natory or other plac islaus Ce	em.	December 10, 2007	Balt	timore.	Maryla	nd
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or othe		21. Signature of Funeral Service Lice		nn	22	. Name and Addre	ss of Facilit					
B	Per din per di		chthous	(onn	elle,	7	onnelly f 110 Solle	unera ers Po	I Home Of int Road,	Dunaz Duna]	aik,P.A lak.Md.	21222	
			23a. Part 1. Enter the disease, or cor	nplications that cause	ed the death.		er the mode of dyin	ng, such as	cardiac or respiratory a			Approximate Interval Bety	een
1	Pnysician		shock, or heart failure. (List only Immediate Cause (Final disease or condition	y 0110 04400 011 0441		uan (	ed i	Den	edua.			Onset and D	Death .
	/Medical		resulting in death)	Due to (or a	s a conseque	nce of):						001. 40.	
	Examiner		Saquentially list conditions,	b									
T	9d Sit	ine.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque	ince of):							
S .	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be defached for use as the burial-transif	Examine	that initiated events resulting in death) Last	c Due to (or a	s a conseque	nce of):	· · · · · · · · · · · · · · · · · · ·						
8760	sician buris	dical E											
687	ficate phy: s the	edlo		0									
Вох	eath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ter .			2	23d. Date of de	livery	
ň	death e atte d for	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant			Ectopic pregnancy Other ( <i>specify</i> )	/			Month	Day Y	/ear
0	at the de by the tached	Physician/Me	9 🗆 Unknown	9□ Unknown									
S, D	res tha igned be det	by P	Part II. Other significant conditions	contributing to death	1 1	_	nderlying cause giv	en in Part I.				the cause of d	
ord	w require been si should b	peq	- January	1	hrule	1	CH.	V/	1□	Yes 2	□No 3□Pi	robably 4 101	łnknown
of Vital Records,	law rias be	Completed	Hypothypide	so ,	(	201	esposi	<u>, , , , , , , , , , , , , , , , , , , </u>	24a. Was		prior to	utopsy findings a	available ause of
R		Con	011				0		perf 1 ☐ Yes	ormed?	death?	2 No	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?						of Death (Check only				
of o	Physi this c	2	1 Yes 2 No	Hospital: 1 Inpat		R/Outpatier		4 140	rsing Home 5 Res			city)	
LO LO		lon	27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year)	8b. Time of Injury	Wor	yat k? Yes 2.⊟i	28d. Describe	now injur	y occurred		
Sic	ten leat tor: the	licat	2 Accident investigate 3 Suicide 6 Could not	be One Diego of It	niury - At hom	ne farm str	eet, factory, office	163 2		(Street an	nd Number or R	ural Route Num	ber.
Division	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide determined	building, e	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	oot, radiory, orrido			wn, State			,
	spita hours ineral		29a. Certifying P	hysician: To the bes	t of my knowl	ledge, deatl	n occurred at the tir	ne, date an	d place, and due to the	cause(s)	and manner as	s stated.	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	ledical	(Check only 2 Medical Exa	miner: On the basis and manner s		on and/or in	vestigation, in my o	pinion, dea	th occurred at the time	, date and	d place, and due	to the cause(s	1
	To t To t	Ž	29b. Signature and title of certifier	<b>)</b> .			29c. Licens		-25/1		te signed (Mont		
•			P M IVE				D	- 50	737	12.	-08-	100 f	
	Ų		30. Name and address of person who	ASECM	death (Item 2	23a) (Type,	Print) BASTB	RN	354. BLUD,	M	-P -2	4221	٠
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 1 0		trar's Signatu	re L	- 18						
			PLUIU	LUUI JURE	What Il		TO THE STATE OF TH						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 2007 9:40p 3 Randolph Wayne Stoneberger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Mt. Airy 4815 Buffalo Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 1**√**2 M 2□F 60 VA March 27 1947 224-58-3140 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Mt. Airy Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21771 4815 Buffalo Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 Wietnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) plumbing Elementary/Secondary (0-12) College (1-4or 5+) plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Stoneberger Rudolph Freeze 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4815 Buffalo Rd., Mt. Airy, MD 21771 Joan Stoneberger (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐Cremation 3 ☐ Removal from State Olney, MD Norbeck Memorial Park12-7-07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Daugesparght sperbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pancreatic cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2**X**1No 2 □ No 1∏ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner sician and burial-transit as the burial Box 68760. The law requires that the death certificate be attending properties for use as P.O. 1 signed b Division or Vital Records, the Hospital or Attending Physician: hin 24 hours after death. Director: After filled in by the 24 hours a within 2

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Randolph Wayne Stoneberger Baltimore, Maryland 21215-0036

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau

**Physician** 

/Medical

31. Date filed (Month, Day, Year) DEC 1 0

29b. Signature and title of certifier

30. Name and address of person w

Dr. Emily Hsu, M.D. 7190 Crestwood Road Frederick, MD 32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per ff 9874 12-10-07 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav 9:46 GM **Physician** MELVIN SCHWEITZER December 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facilify Name (If not institution, give street and number, Examiner Baltimore Hospital N/A Baltomore Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex / 1X M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 072-28-5107 10/03/1935 ŃΫ Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No **Funeral Director** MD BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3011 FALLSTAFF ROAD UNIT 308 21209 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🕅 No Specify. U.S.A. Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SALES **FURNITURE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JACK SCHWEITZER KATZ 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GLENDA SCHWEITZER / WIFE 3011 FALLSTAFF ROAD UNIT 308 - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place)
MI KRO KODESH BETH 12
BETH I SRAEI me and Address of Facility 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State 12/07/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lymphoma /Medical Due to as a consequence of) 8 months **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 24 hours a er dear 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier luman MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 2401 W. Belvedere Ave Baltimore, MD 21215 Sinai Hospital 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State

Streve &

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Martin 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

12955en, m,11

1 0 29c. License number

21 Crossroads Dr. #400 Owings Mills,MD 21117

1)4256

29d. Date signed (Month, Day, Year)

12/6/2007

STROTHER, CADENCE Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, ぐ

		riec	State of				. Elisure A Health and N	•	•	
		1 State	State Of	iviai yiaiiu /		tificate of		, ,	0007	20100
- NO. 1		Registrar  1. Decedent's Name (First, Midd.	lle. Last)		Oeri		Deatii	2. Date of Dea	Reg. No	3. Time of Death
Physici		Cadence	Yvonne	C+,	<del>-</del> - lo .			Month	Day Year	n
/Medic Examin		4a. Facility Name (If not institutio			rothe		or Location of Death	Decemb	er 2 200 4c. County of Dea	
-Admin		Greater Bal	timore M	edica1	Cent		Towson		Balti	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		rthplace (State or Foreign ountry)
Director		none	1□ M 2 <b>M</b> F		Yrs.	Wortins Days	0 6	12,02		ID
and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, To	own or Loc	ation				10d. Inside City Limits
Aaryk f sho ed at	ō									1 □ Yes 2 No
the N 28a-	Director	MD 10e. Street and Number		Nott	ingl	10f. Zip Code			10g. Citizen of What C	'
with 3a or 1 be	Ö									ounity:
ms 2	Funeral I	47 Aven Way	12. Was Dece	dent Ever in U.S.	13. W	21236 /as Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Am	
after or ite nine	F	1 Never Married 2 ☐ Mar	Armed For ried 1 Yes If Yes, Give	ces? 2 No		Yes, specify Cub.  ☐ Yes 212 No		Rican, etc.)	Black, Whi	te, etc.
ours iral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	tes:	'	LIYES ZEZINO	Specify:		Specify: B1	ack
72 h 'natu dical	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16	6a. Decede (Give k	ent's Usual Occup	oation during most of work d)	ing I	16b. Kind of Business	/Industry
vithin ne. han '	шb	Elementary/Secondary (0-12)	College (1-	4or 5+)			d)			
iled v Hygie <b>ther t</b>	ပ္ပ	17. Father's Name (First, Middle,	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )		Infa	ant	19 Mothor's Name	/Eirot Middle	Infant Maiden Surname)	
d be fantal he	Be c		•					e (First, Wildale, I	waiden Surname)	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	우	Scott  19a. Informant's Name/Relations		rother	9h Mailing	Address (Street	Geri and Number or Bur	al Route Numbe	Strothe r, City or Town, State,	
and 2 sealth an n 27 is ner trau		Scott & Geri	, , , , ,							
s 1 a othe		20a. Method of Disposition		20b. Place	of Dispos	tition (Name of atory or other place		Nottir	19ham, MD 20c. Location - City or	
Pages nent of I int: If ite		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5		state	Co. / C	To the street place	m 12/4	12007	BAND C	In the
보는 반면 등		21. Signature of Euperal Service	· · · · · · · · · · · · · · · · · · ·		221	Name and Addre	se of Facility	L 8 500	150h	1, 2.
Depa Impo any ii		MINE	all		16	0924 YO	NKKO.	Dong	E som no	2221
		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that ca t only one cause on ea	used the death. D	o not ente			or respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	e e	XTREME	1	KEMAT	WATY			Onset and Death
/Medical Examiner		resulting in death)	Due to (c	or as a consequenc	e of):					31113
-Adminior	<u>.</u>	Sequentially list conditions,	b	or as a consequent						
rted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Z mente	as a Guidiniciphicino	40 OB)					
be executed ician and burial-transit	Exal	that initiated events resulting in death) Last	c Due to (c	r as a consequenc	e of):					
eath certificate be executed attending physician and for use as the burial-transit	ca		d							
rtifica ng ph as th	Jedi	IS SEMAN S.								
th ce tendii r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome pf pregnancy rth 2□Fetal dea	nth 3⊟E	Ectopic pregnancy	1		23d. Date of de	,
e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		int at time of death		Other (specify)	<u> </u>		Month	Day Year
hat the de d by the a letached	Physician/Med	Part II. Other significant condition	ene contributing to do	ath but not regulting	in the une	larluing course six	en in Death	00 - Dida-		
The law requires that the death certificate tte has been signed by the attending physionage 2 should be detached for use as the	ğ	Tarrii. Other Significant condition	Monto		in the unc	enying cause giv	en in Fan I.		bacco use contribute t	robably 4 TUnknown
v requ	Completed		. 0116							
has be 2 s	mp							24a. Was a autops perfori	by prior to	utopsy findings available completion of cause of
		OF Was ones referred to madical						1□ Yes	2 ☑No 1 ☐ Yes	s 2□No
ysician: is certific director,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	patient 2 ☐ ER/0	Dutpatient	2□ DOA Othe	er:			
g Phy er this eral d	2	27. Man r of Death	28a. Date of	Injury 28b	. Time of	3 DOA 28c. Injur	4   Nursing Ho		ence 6 Other (Spe	ocify)
nding tth. r: Aft	ioi	1 ✓ Natural 5 ☐ Pendin 2 ☐ Accident investig	19	, Day Year)	Injury		k? Yes 2∐No			
r Atte er deg recto by th	iii	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	28e. Place o	of injury - At home, g, etc. (Specify)	farm, stree	et, factory, office			treet and Number or R	ural Route Number,
tal or rs afte al Dii	Certification:			g, cio. (Opecny)				City or Towi	i, State)	
Hospi 4 hou Tuner ely fill	edical	(Check only 2 Medical	ng Physician: To the b Examiner: On the bas	est of my knowled	ge, death o	occurred at the tirestigation, in my o	ne, date and place,	and due to the c	ause(s) and manner a	s stated.
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificy completely filled in by the funeral director.	Med	one)  29b. Signature and title of certifier	and manne	er stated.		29c. License				
- × × 0	_	Man Land	a tono	-0:-	•	_			9d. Date signed (Mont	
	-	30. Name and address of person	who completed cause	of death (Itam 22a	) (Type P	int)	46156	,	y COLIVED	16 2, 2007
Ø		GRM( /	2701 A	Charle	2) _ <	A	Buton	re mi	7 21204	
Stat	е	31. Date filed (Month, Day, Year)	2007 Re	gistrar's Signature	53		1-0-0-1111	-/		
Registra	ir	MECTA	MINI THE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 23, Month 2007 2:45 AM M November James Shields 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Months Days Hours Min. unk 212-48-0970 Aug 28, 1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2936 Yorkway #B 21222 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace 11. Marital Status unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 828 Eutaw Street Baltimore, MD Joseph Richey Hospice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in sţate 21. Signature of Euneral Service Licensee Ronald S. Wade, Director 28 Partend Addat of Figilit Board 655 W. Baltimore Street 21201 Baltimore, MD 21 a. Par 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or regiments should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ogditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably iknown

**Physician** /Medical **Examiner** 

> the burial-transit sician and

certificate has been signed by the attending p ector, page 2 should be detached for use as

this certificate

filled in by the funeral

Medical

24 hours after death e Funeral Director:

within 2

Records, I

Division or Vital

or Attending Physician:

Hospital

**Physician** 

/Medical

Examiner

10a State

MD

Director

Funeral

Completed by

Be

၉

unk

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

al Hygiene.

marked other traumatic

Pages 1 and 2 should be finent of Health and Mental I

permit. Pages 1 and Department of Healt Important; If item 2 any Injury or other:

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Examine Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

2 No

1 Inpatient

(Month, Day Year)

28a. Date of Injury

24a. Was an autopsy performe 1 Yes 2 1 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence Other (Specify 28c. Injury at Work? 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 🗌 Yes

27. Manper of Death

1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3□ DOA

M

29c. License number 29b. Signature and title of certifie

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

death (Item/23a) (Type, Print)

5 Pending investigation

6 ☐ Could not be

determined

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Registrar

State

Division or Vital Records, P.O. Box 68760.

		Please	State of Maryland				_	_	
		1 - State Registrar		Ce	rtificate of Death		Reg.	No.2 0 0 7	301.02
13		1. Decedent's Name (First, Middle, L	ast)				ate of Death	2001	3: Time of Death
Physici /Medic		Leslie Smith						Day Year 28, 2007	4:13 AM M
Examin		4a. Facility Name (If not institution, ga	ive street and number)		4b. City, Town, or Location of	f Death		4c. County of Dea	
		Southern Maryla	nd Hospital		Clinton		:	Prince G	eorge's
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. las		If Under 1 Year If Under 2 Months Days Hours		ate of Birth Month, Day, Ye	9. Bir	rthplace (State or Foreign ountry)
Director		577-62-8763	1XM 2□F 77	Yrs.			b 15,		th Carolina
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
farylarylarylarylarylarylarylarylarylaryl	ō	,			arlboro				1 ☐ Yes 2 ☐ No
the N 28a-i	Director	10e. Street and Number		PCI II	10f, Zip Code		100	Citizen of What C	
with a or t be r		119 Kettering Dr	i				log.	Onizen of What O	ountry:
eath	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13.	20772 Was Decedent of Hispanic Orio		es or No-	USA 14. Race - Am	erican Indian.
fter d r Iten	Ψ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	, Puerto Ricar	i, etc.)	Black, Whi	te, etc.
urs a al', o Exam	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:			Specify: b	lack
2 hor	ted	15. Decedent's I			dent's Usual Occupation		168	o. Kind of Business	/Industry
thin 7 e. an "r Med	ble	(Specify only highest g	College (1-4or 5+)	life.	kind of work done during most DO NOT use retired)	or working			
filed within 72 hours after death with the Maryland Hygiene. wher than "natural"; or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	6	Ŏ	gro	unds keeper			ostal se	rvice
be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Las	,			•	,	den Surname)	
should be nd Mental marked o	၉	Leslie Lee Smit	h Sr		Flo	rence !	Newkirk	ζ	
2 short and ls m		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street and Numbe	r or Rural Ro	ite Number, C	ity or Town, State,	Zip Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Jessie Green/sis			7 Jasper Stree				
Pages 1 and of He Int. If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	con	netery, cre	osition (Name of matory or other place)	Date	200	c. Location - City or	r Town, State
permit, Pages Department of Important: If it any injury or o		4☐Donation 5 NOther (Spec	ify) in state						
permit Depar Impor any in once.		21. Signature of Funeral Service Lice Ronald S	Wade, Director	S	2. Name and Address of Facility tate Anatomy Bo	y pard 65	55 W. B	altimore	Street
<u> </u>		John Mill	Will-	Ba	altimore, MĎ	<u>2</u> 1201			
Physician /Medical Examiner	niner	23a. Part I Enter the dise, se, or or shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury)	a.  Due to (or as a consequent  Dualto (or as a consequent	ocard nce of): Herent	had Inkarton Dream	۸			Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. Due to (or as a consequence)  d.  23c. If yes, outcome pf pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dea 9 □ Unknown	ey eath 3[	⊒Ectopic pregnancy ] Other (specify)			23d. Date of de Month	elivery Day Year
ires that the de signed by the	þ	Part II. Other significant conditions	contributing to death but not resulti	ng in the u	nderlying cause given in Part I.	2	23e. Did tobac		o the cause of death?
w requir been si should I	etec					-			
Physician: The law this certificate has larial director, page 2 s	Completed						24a. Was an autopsy performed □ Yes 2 □	prior to death?	utopsy findings available completion of cause of s
clan: ertific	Be	25. Was case referred to medical examiner?	I de a cidado			of Death (Che	eck only one)		
Physical direction	은	1 Yes 2 No						e 6 □Other (Spe	ecify)
ing After une	ö	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	(Month, Day Year)	8b. Time o Injury	Work?		Describe how i	injury occurred	
tend leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not		-	M 1 Yes 2 N				
or Al fter d Direct in by	Certification:	4 ☐ Homicide determined		e, farm, str	eet, factory, office	28f. L	ocation (Stree City or Town, S	it and Number or Fi State)	lural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical Ce	29a. Certifier (Check only one)  29a. Certifying P 2 Medical Exa	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, deat n and/or in	h occurred at the time, date and vestigation, in my opinion, deat	d place, and d	ue to the caus the time, date	se(s) and manner a	s stated. e to the cause(s)
o the	Mec	29b. Signature and title by gertifier	and marinor otation.		29c. License number		29d.	Date signed (Mon	th, Day, Year)
F 3 F 0	,	Kfahn	u mj		00055120		No	vember 2	
		30. Name and address of person who	o completed cause of death (Item 2:	3a) (Type,	Frint) SE Smik 310 h	sching	ba DC	20032	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e Aga	B3 0			0-	
Registr		DEC 1 0 200	Mayer 15	A STATE OF THE PARTY OF THE PAR				<del></del>	

			For State Registrar		State of	Marylar		artmen			nd M	ental F	lygie	ne N200	7	39	403
2	Physici /Medic		1. Decedent's Name ( HOME)		HAFFER,	SR.						2. Date of Month DEC.		Day 2007	Year		of Death
	Examin	7.0	4a. Facility Name (If n	ALTIMORE	STREET			BAL	TIMO					4c. County			
	Funeral Director		5. Social Security Num  199-20-60  Usual Residence of D	019 1	ex MM 2□F	80	(ast birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of (Month, OCT.	Day, Ye	1927	9. Birthp Coun	lace (State try)	e or Foreign A •
	Maryland	tor	10a. State MD .	IOb. County	A		ty, Town or Lo BALTIMO		-						1		City Limits es 2 ☐ No
	er death with the Marylan Itama 23a or 28a-f ahow Let Lorel Let Doublie Jat	al Director	10e. Street and Numb		E ST.			10f. Zip	Code	212	224		10g.	Citizen of W	hat Coun	try?	
036	E o at	by Funeral	11. Marital Status 1 ☐ Never Marriec 3 🏋 Widowed 4		12. Was Decede Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? No	1	Was Deced f Yes, spec 1 ☐ Yes 2			in? (Spe Puerto I	cify Yes or Rican, etc.)	No-		k, White,	an Indian, etc. WHI:	
Maryland 21215-0036	d within jiene. r than	Completed		5. Decedent's Ec only highest gra dary (0-12)		or 5+)	life. L	dent's Usua kind of wor DO NOT us MECH	k done di e retired)	uring most	of workii	ng	168	b. Kind of Bu		dustry	
/land	be file ntal Hyg nd othe avent,	To Be C	17. Father's Name (F)									(First, Mia		den Sumam	9)		
	s 1 and 2 should f Heelth and Mer Itam 27 Is marks other traumatic		19a. Informant's Nam SHARON P	IETROWSK			835 J	AYDEE	AVE		INDAI	K, M	ARYL		1222		
Baltimore,	permit. Pages 1 Depertment of H Important: If Ital any injury or ott		20a. Method of Dispo- 1 Burial 2 X 4 Donation 5 21. Signature of Fune	Cremation 3 C	/	ate		MATOR  . Name and	th <i>er place</i> Y d Address	1 s of Facility	2/11 CH		7 S.	BALTIM ZEILER E, MAR	ORE,	MARY CN,	INC.
4	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cassa (Fi disease or condition resulting in death)  Sequentially list cond	nal	a	as a consec	quence of):	er the mode	of dying		1	r respirator	^			Approxim Interval E Onset an	Between
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and coage 2 should be detached for use as the burlat-transit	dical Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) La:		с.	as a consec	Se	~ D			-						
P.O. Box (	it the death certifica by the attending pt tached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ i 9 ☐ Unknown	onths?	23c. If yes, outco 1□Live birtl 4□Pregnan 9□Unknow	n 2 ∐Feta It at time of c	al death 3	Ectopic pre Other (spe					_	23d. Date Mor	of delive	ny Day	Year
	w requires that been signed k should be deta	þ	Part II. Dther significa	ant conditions o	ontributing to deal	th but not res	sulting in the ur	11/	ause give	n in Part I.		•	□ Yes		3 D Prob	ably 4	of death?  Unknown  gs available
tal Re		e Completed	25. Was case referred	d to medical		16	10.1			26 Place	of Death	a	utopsy erformer s 2	1?/ d	rior to cor eath?	npletion o	cause of
Division of Vital Records,	tending Physileath. tor: After this the funeral dis	Certification; To B	2 Accident 3 Suicide	5 Pending investigation 6 Could not be determined	28a. Date of (Month,	Injury Day Year) Injury - At h	ER/Outpatien 28b. Time of Injury	M 25	A Other  Bc. Injury Work' 1  Y	r: 4 🗆 Nur:	sing Hor	ne SA	esidenc	e 6 ☐Othe	∍d		umber,
ā	를 다 드	ai Certi	4 Homicide  29a. Certifier	Certifying Ph     Cer	ysician: To the be	est of my kno	owledge, death	occurred a	at the time	e, date and	I place, a	ind due to	Town, S	e(s) and mar	ner as st	ated.	
		Medical	29b. Signature and tit	le of certifier	niner: On the basi	r stated.		) )	in my opi		occurre J	ed at the tin	29d.	Date signed	(Month,		
	1271 Sta	te	DR. SCAL: 31. Date filed (Month,	IA 280	1 HUDSON	•	BALTI	,	MAR	YLAND	) 2]	1224	-				
DH	Registr MH 17 Rev 1/20	ar		DEC 1 0	2007	elve-	B A	pret	Ì								

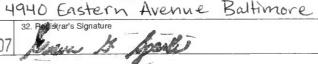
Division or Vital Records, P.O. Box 68760, n 24 hours after death.

The Funeral Director: A pletely filled in by the fu the within 24

> State Registrar

Dr. Sarah Risen 31. Date filed (Month, Day, Year) DEC 1

29b. Signature and title of certifier



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

December 05 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 Amend Item 29d per dr., 874,12/07/97/11 Pate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :10 AM 07 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ubman Lanc 0 Hari TOWER If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral**  Birthplace (State or Foreign Country) 8. Days 1 ☐ M 2 🗹 F Months Year) Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f ehow 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at 1 Pres 2 □ No Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 936 bMan Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify 3 Widowed 4 □ Divorced 140 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maider ဂ္ iam IUN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Town, State, Zip Code) 68 other Linden 20b. Place of Disposition (Name of cemetery/crematory or other place 20a. Method of Disposition Date 20c. Location permit. Pages Depertment of Important: if it any njury or o 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Addr s of Facility 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiago Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Day /Medical Dug to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) the 9 Unknown 9 Unknown been signed by t should be detact significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has tirector, page 2 s 24a. Was an autopsy performed? 2 No 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this re the Funeral Director; Alter th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending investigation Injury death. М 2 Accident 1 ☐Yes 2 ☐ No within 24 hours effer deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Hospitai Entifying Physician: To the best of my knowledge, death secured at the time, data and place, and due to the causa(s) and macrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of pertifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

em 23a) (Type, Print)

. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

		For State		State o	f Marylar	-	artment of F		Mental Hy	/giene Reg. No	0007	201.07
2		Registrar  1. Decedent's Name (First,	,	,	/		imodio or i		2. Date of D			3. Time of Death
Physici /Medio		MARTHA		VUKO'					DECEM	BER "	7 2007	2:48 AM
Examir	er	4a. Facility Name (If not ins				in		r Location of Deat これいにた	n	40.	County of Death N/A	
Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year)	•	
Director		216-24-0453 Usual Residence of Decede			77	Yrs.			March	20,1	193 <b>0</b> Ma	ryland
nyland show	_	10a. State 10b. C	ounty		10c. Ci	ty, Town or Lo	cation				1	Od. Inside City Limits
the Ma 28a-f s	Director	Maryland 10e. Street and Number	Ва	ltimor	e		10f, Zip Code		Dunda1		zen of What Cour	1 ☐ Yes 2X No
3a or	Ö	7126 Marte	ell Av	enue			Tot. Zip Code	2 <b>1</b> 222			ited Sta	
aryiand ZIZI3-UU30 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notitled at	Funeral	11. Marital Status		12. Was Dece	edent Ever in U	J.S. 13.	Mas Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 1	14. Race - Americ Black, White,	
rs afte rs, or it xamin	by Fi	1 ☐ Never Married 2 ☐ 3 ☐ Widowed ★★ Div		1 ∐Yes If Yes, Gi Year or D	ve		1 □ Yes 2 □ kNo	Specify:			Specific	White
3-UU36 72 hours af "natural", or dical Exami			cedent's Ed	ucation		16a. Deced	dent's Usual Occup	ation	rking	16b. Kir	nd of Business/In	
vithin vithin the	Completed	Elementary/Secondary (0		College (	1-4or 5+)		kind of work done of the contract of the contr	•	rking		landar 1	
G Z filed v Hygie other t	ပို	8 Years 17. Father's Name (First, M	liddle, Last)				Secretary	18. Mother's Na	me (First, Middle		lerical Surname)	
Viand uld be file Mental H arked oth	To Be	Joseph Miku	ıla					Anna	Yancura	L		
DallIIIIOTCE, INIGIT/JIGING ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at ance.		19a. Informant's Name/Rel Stacey Mille		ype. Print) Daught	er)		ng Address <i>(Street :</i> Epsom Ro		ural Route Num Son, Mar			Code)
ore,	1	20a. Method of Disposition  XX Burial 2 □ Cremi	ation 3 🗆	Removal from		Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Loc	cation - City or To	own, State
DallIIMOrd  permit. Pages ' Department of F Important; if ite any injury or of		4 □ Donation 5 □ Ot	her ( <i>Specify</i>			cred H	t. of Jes	us Cem.	12/10/2	007	Dundalk	, MD
Dall permi Depa Impo any ii		21. Signature of Juneral Se		Ev	W		Name and Addre Duda-Ruck 7922 Wise					
		23a. P. m. Enter the disea shock, or heart failure	se, or comp	lications that one cause on e	cay ed the dea	th. Do not ente	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,	Ziano Zi	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)					HRWOF					Onset and Death
/Medical Examiner		resulting in death)		Due to	(or as a consec	quence of):						
	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying		b. Due to	(or as a consec	quence of):						
And and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c	(or as a consec							
cate be executed physician and the burial-transit	dical E	,	l	d.	(or as a consec	quence on.						
rtificat ng phy		IF FEMALE:		· ·				-				
w requires that the death certifuents that the attending should be detached for use as	Physician/Me	23b. Was decedent pregna in the past 12 months	ini I	1□Live b	tcome pf pregn pirth 2 ☐ Feta nant at time of a	al death 3 □	Ectopic pregnancy	1		2	3d. Date of deliver	ery Day Year
the de arched	nysic	1 □ Yes 2 □ No 9 □ Unknown		9□Unkn		geam 5L	Other (specify)					
S, T	by Pl	Part II. Other significant co	onditions co	ontributing to de	eath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us		he cause of death?
w requires to been signeral should be a	ted								1	Yes 2	∏No 3∏ Prot	oably 4 ☑Unknown
ne law has b ge 2 sl	Completed				<u> – – –                               </u>		. <u>-</u>		24a, Was auto peri	s an opsy formed2	24b. Were auto prior to co death?	ppsy findings available impletion of cause of
hysician: The law his certificate has be director, page 2 s		25. Was case referred to m	edical					26. Place of De	1□ Yes	2 No		2 □ No
nysicia nis cer direct	To Be	examiner? 1 ☐ Yes 2 No	-	Hospital: 1 🗹	Inpatient 2□	] ER/Outpatien	t 3 DOA Oth	or:			3 □Other (Specil	
ling Phy After thi uneral o	on:	27. Manner of Death 1 ☑ Natural 5 ☐ F	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	Wor		28d. Describe	how injury	y occurred	
Attend death death sctor: y the i	ficat	3 ☐ Suicide 6 ☐ C	nvestigation Could not be letermined	28e. Place	of injury - At h	ome, farm, stre	M 1 D	Yes 2 □ No	28f. Location	(Street and	d Number or Run	al Route Number.
tal or safter al Dire	Certification:	4 ☐ Homicide	ictermined	buildi	ing, etc. (Speci	fy)			City or To	own, State)	)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical (	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Phy dical Exam	Iner: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or in	n occurred at the tirvestigation, in my c	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) e, date and	and manner as s place, and due t	tated. o the cause(s)
To the within To the Comp	M	29b. Signature and title of	ertifier	D.			29c. Licens				e signed (Month,	_
		· yus	m IC.	1 rue	<b>540</b>			-000		DRUK	EMBER 1	7 2001/
5		JUSTIN 1	R. PX	completed caus	se of death (Iter	m 23a) (Type, 1	RAST	RIZN A	VENUE	BAL	Timork,	M.O. 21224
Sta Registr		31. Date filed (Month, Day,		32. F	Registrar's Sign	ature	الم					
DHMH 17 Rev 1/20	- 6	DEC 1	û KUNT	Jan State St	DAM. W.	-			· · · · · · · · · · · · · · · · · · ·			

State Registrar Road

eldersburg

30, Name and address of person who completed cause of death (Item 23a), (Type, Print)

645

istrar's Signature

Illian Tan

DEC 1 0 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death lent's Name #First, Middle, Last Day Month Year **Physician** 2007 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Yea) Social Security Number 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🕶 F Hours 220-38-6522 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at Baltimore MD 1 Nes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 Who If Yes, Give Year or Dates: 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. 1XNever Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ve kind of work done
DO NOT use retire Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' College (1-4or 5+) dary (0-12) 17. Father's Name (First, Middle, Last) UNK Be vlarie. 9a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number Balto, MD aton the. ethod of Disposition 20c. Location Burial 2 Cremation 3 Removal from State 1 Burial 2 □ Oremano. 4 □ Donation 5 □ Other (Specify) Baltimore, 21. Sign du e of Funeral Service Licensde 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Un known **Physician** Arterio scleratic Coronary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and de detached for use as the burial-transit Due to (or as a consequence of) DÍvision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Zeath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar 2007 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200<sup>Year</sup> Weir Sr. **Physician** Lester Palmer 0342 December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) April 24 1919 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Months Days Hours 227-14-4336 1 X M 2 □ F 88 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MDHoward West Friendship 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21794 USA 1825 McKendree Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) home improvement carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Belle Goss Albert Palmer Weir 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 McKendree Rd., West Friendship, MD 21794 Mary Weir (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial 12-10-07 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Daige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) rostate eap **Physician** /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): physician Box 68760 pe Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After completely

> State Registrar

31. Date filed (Month, Day, Year) DEC 1 0 2007

29b. Signature and title of certifier



and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Jecenber 7, 2007

		1	For State Registrar	State of M	arylanu /		ificate			iu ivi	ental Hyg	ig. No. 1	0.7	39	411
	Physicia	_	Decedent's Name (First, Middle, L Oscar: Williams	ast)							2. Date of Deat Month 12	h Day O4	Year 2007		of Death P M
	/Medic	al	la. Facility Name (If not institution, g	ive street and number)	)		4b. City, To	own, or	Location of	Death	12		nty of Death	4:20	Р
	Examin	er	Rock Glen Nursing			er			Balt	timor	e				
	Funeral		5. Social Security Number 6.		ge (In yrs. last b	irthday)	If Under 1 Months	Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, Sept. 7,	Y9324	9. Birth	place (Stati ntry)	or Foreign unk
	Director		212-20-0250 Usual Residence of Decedent			113.					БОРСТ 1,				
vland	Wo #	-	10a. State 10b. County		10c. City, Tox	wn or Loca	ation								City Limits as 2 □ No
e Mar	Sa-1 Si	cto	MD				1		imore			On Civinan	of What Cou		
h with th	3a or 26 st be n	۵	10e. Street and Number 10 N. Rock Glen Ro	oad			10f. Zip C	Code	21229			U	SA		
:1215-0036 within 72 hours after death with the Maryland	popular ragos in the state and Medial Hygiene. Important if item 27 is marked other then "netural", or items 23a or 28a-f show important: If item 27 is marked other then "netural", or items 12a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at once.	by Funerai	11. Marital Status unk 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1  Yes 2  If Yes, Give Year or Dates:	? unk		as Decede Yes, specif	_	spanic Origi n, Mexican, Specity:	in? (Spe Puerto I	cify Yes or No- Rican, etc.)		Race - Amer Black, White rican Ar echy:	, etc.	
Maryland 21215-0036	ne. hen "netur v Mazical I	Completed	15. Decedent's (Specify only highest (Secondary (0-12)	Education trade completed) College (1-4or		(Give k	ent's Usual ind of work O NOT use	done a	luring most	of worki	ng <b>un</b> k	16b. Kind o	f Business/li	ndustry	unk
and 2.	ad other t	Be	unk   17. Father's Name (First, Middle, La	st) unk					18. Mother	's Name	(First, Middle,	Maiden Sun	name) un	k	
Maryla 12 should	h and Mei 7 Is mark treumatic	ို	19a. Informant's Name/Relationship Maria Valdenegro								d Route Number			ip Code)	
	Department of Health Important: If item 27 I any injury or other trees once.		20a. Method of Disposition  ™⊠ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place cemet	of Dispositery, cremi	ition (Name atory or oth	e of her plac	θ)		ate	20c. Locati	on - City or I		
Baltimore,	Departmer Important any injury		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lin		PROUITC	22.		Addres	s of Facility	W	ylie Fune Baltimore	ral Ho	me, P.A		
	10200		23a. Part1. Enter the disease, or c	mplications that cause	ed the death. Do								21211	Approxir Interval	nate Setween
	nysician /Medical xaminer		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. MRS	A N s a consequence	ect	ed		nul	3	le co	lecu Vila s	65 hu	Onset a	days
V	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a	s a consequenc	e of):							V		
	are be executively side of the purial-train	cal	that initiated events resulting in death) Last	c	s a consequenc	e of):									
P.O. Box 68	The law requires that the beam certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dea at time of death		Ectopic pre Other (spe					23d	. Date of deli Month	very Day	Year
ds, P.	n signed by	þ	Part II. Other significant condition	s contributing to death	but not resulting	g in the un	nderlying ca	ause giv	en in Part I.	<u> </u>		es 2 🛣 N	contribute to		of death? □Unknown
Vital Records,	ine law requir sate has been si page 2 should I	Completed	PERIPHERI	AL VASO	CULA	2 D	ISE	JSE			24a. Was autop	an 2 sy rmed? 2 No	th. Were au prior to death?		igs available of cause of
		BeC	25. Was case referred to medical examiner?						26. Place	of Deat	h Check onl o	пе			
of V	dis.	10	1 ☐ Yes 2 No		tient 2 ER/		_	and the last	4 ENVIOL	rsing Ho	me 5 Resid			city)	
	After After fune	ion:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	o. Time of Injury	M	8c. Injur Wor 1 □	yat k? Yes 2.⊟1	No	200. Describe i	iow injury o	CCUITEG		
Division	death death ctor: y the	Certification;	2 Accident Investigation 3 Suicide 6 Could not determine	t be 28e. Place of I	Injury - At home, etc. (Specify)	, farm, stre		r, office			28f. Location (S City or Tox	Street and N vn, State)	lumber or Ru	ıral Route l	Vumber,
_	To the Hospitel or Attent within 24 hours after deal To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physicien: To the be- xeminer: On the basis and manner	of examination	dge, death and/or inv	occurred a	at the tir	me, date an opinion, dea	d place, th occur	red at the time,	date and pi	ace, and due	to the cau	
,	To th within To th compl	Me	29b. Signature and title of certifier	le za	we man	0	290		8 100 8	362		29d. Date s	signed (Mont	Day, Yea	7 <b>,</b>
^			30. Name and address of person w	no completed cause o	of death (Item 23	a) (Type,	Print)	ns	Ave	8	wie 11	-10 .	Balli	move.	, , ,
	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 0	2007 32. Agi	strar's Signature		sedi)	•						G -1.	

07-09378

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

ames Younger		- For State	of Maryland / De	epartment of F Certificate of D			eg. No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Las				2. Date of Deat	h /	B. Time of Death
Medical Examin	er	James Younger				Month December		1934 hrs
7	Í	4a. Facility Name (if not institution, given 1802 Edmondson Avenue			City, Town, or Location of Baltimore	or Death	4c. County of Death	
Funeral		5. Social Security Numbernk 6. Se				<del></del>	th(MM/DD/YYYY) 9. Bir	n
Director		<b>214-40-0673</b> 1 <sup>X</sup>	M 2 F	65 <sub>Yrs.</sub>	Months Days Hours	Min. Feb 20	), 1942 co	untry) Maryland
any	-	Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or Location				10d. Inside City Limits
		MD		Baltimo	re			1 X Yes 2 No
Maryland 28a-f show d at once	Director	10e. Street and Number	WONIIO		Of. Zip Code 21217	1	0g. Citizen of What Cou USA	ntry?
the la or		1802 Edmondson A	12. Was Decedent Ever i	in IIS 13 Was I	Decedent of Hispanic Onc	gin? ( Specify Yes or No		ican Indian, Black,
items	Funeral	11. Marital Status  1 Never Married 2 Married	A C	unk If Yes	, specify Cuban, Mexican		White, etc.	
after d	ğ F		If Yes, Give Year or Dates:	1 Y	es 2 X No specify:		Specify: b1;	
2 hours afi "natural"	fed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	d) 16a. Decedent's during mos	Usual Occupation (Give t of working life, DO NOT	use retired)	TOD. MING OF BUSINESS/	Industry unit
036 ithin 72 rne. r than '	Completed	unk 8	unk	Carpen			Hone Improve	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Last				's Name (First, Middle,		unk
2121 uld be fil Mental I marked	To Be	Roy Clifton Younge 19a. Informant's Name/Relationship (7	r Sr.	19b. Mailing (	Address (Street and Nun	ie Esther Tist nber or Rural Route Nur	nber, City or Town, State	Zip Code)
O 등 등 등 를	L	19a. Informant's Name/Relationship (			Rut land Avenue enn Street			
Baltimore, ML pemit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traumy.		20a. Method of Disposition  1 Bunal 2 Xremation 3		crematory or othe		Date	20c. Location - City of	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 X Other Specify	invatate	Metro Crema		12/13/07	Raltimore, M	
Balt permit Depart Impor	- 1	21 Signature of Funeral Service Licer Ronald S.		or 461	me and Address of Facilit EC Ang Eomy F Park Hets Av	e Baltimore	Maryland 212	15 treet
Physician	+	23a. Part I. Enter the disease or comparing fallure. List only one cause on e	olications that caused the dach line.	eath. Do not enter the	mode of dying, such as o	cardiac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and
/Medical aminer		Immediate Cause (Final disease or condition resulting in death)	Hypertensive Athero		vascular Disease			Death
A /		b	Due to (or as a consequen	ice or):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequen	nce of):				
- i	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	nce of):				
xecuted n and - trans	ale E	UNPENDED d		1 10 15 00-	00 DEDICT (************************************	12/12/07 12		
60, te be e hysician	Medical	IF FEMALE:	X AMENDED #5,9,1		44, PEKEII, GO/4,	12/12/U/,WD	23d. Date of delive	ry
687 ertifica ding pl	ian/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time	2 Feta		ic pregnancy	Month	Day Year
30x death c	Physician/	1 Yes 2 No 9 Unknow	,	or death 5 Othe	er (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the un	derlying cause given in P		tobacco use contribute to	the cause of death?
IS, P luires th	ted b					24a. Was		outopsy findings available
cord law req has bee	Completed			<u> </u>		auto perfe	psy prior to ormed? death?	completion of cause of
Re( : The ificate r, page		25. Was case referred to medical			26.Place of Death		2 <b>V</b> No 1	res 2 No
Vital ysician his cert directo	o Be		Hospital: 1 Inpatient 2	2 ER/Outpatient	Other	Nursing Home 5	Residence 6 Oth	er: Scene
ing Ph After tl uneral	on: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj			how injury occurred	
Sion Attend death. retor:	catic	2 Accident 5 Pending Investigat	tion 28e Place of Injury	At home farm street	1 Yes 2 , factory, office building, e		(Street and Number or F	Rural Route Number, City
Divi tal or / rs after al Dire	Certification:	3 Suicide 6 Could no determine	be	, a nome, term, seece	,y, omeo bunding, c	or Town,		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Physic	cian: To the best of my kno	wledge, death occurre	ed at the time, date and p	lace, and due to the cau	use(s) and manner as sta	ated.
To the within To the comple	Medical	2 🖳	er: On the basis of examinat and manner stated.	tion and/or investigation	on, in my opinion, death o		29d. Date signed (M	
	Σ	29b. Signature and titla of certifier			O.C.M.E.		December 5, 20	
		30. Name and address of person who	completed cause of death	(Item 23a)			<u> </u>	
			ant Medical Examine	r 111 Penn St	reet, Baltimore, MD	D 21201		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	de			
DHMH 17 Rev 1/20		UEU L V	CUULT ASSESSED	ORIGINAL	- 10			

		1	For State	State	of Maryl		artment of H				giene Reg. No.	200	17	39	413
	-		Registrar     Decedent's Name (First, Middle)	, Last)						2. Date of Dea		V.	ear	3. Time of	
	Physicia	*	TAJ	ANV	NAR					Month /	Day ZZ		7	612	PM
	/Medic Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, o	r Location	of Death		4c. C	County of I	Death		
			Howard County Gen	eral Hospit				lumbia					lowar		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 △ F		yrs. last birthday,	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)		Count	ace (State of	_
	Director		220-76-2824	ILIM 285 F		79 Yrs.				April 15	, 1928	;	Pa	akistan	L .
	pud •	-	Usual Residence of Decedent  10a. State 10b. County		100	. City, Town or L	ocation						10	0d. Inside C	ity Limits
	faryla sho ed at	5		Howard			Co1:	ımbia						1 ☐ Yes	2 <b>⊠</b> No
	the N	Director	Maryland   10e. Street and Number	помаги			10f. Zip Code	Ino I G			10g. Citiz	en of Wha	at Coun	try?	
	with with the r	٥	6316 Amherst	Venue				21046				U.	.S.A.		
	ns 23	Funeral	11. Marital Status	12. Was De	ecedent Ever	in U.S. 13.	Was Decedent of H	lispanic O	rigin? (Sp	ecify Yes or No	- 1	4. Race -	America White, e		
٥	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show drai Examiner must be notified at		1 Never Married 2 Marr	ied 1 ☐ Yes	Forces? s 2 🔀 No Give		If Yes, specify Cub 1 ☐ Yes 2 ☐ No			nican, etc.)		Specify:		Asian	
2-003p	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:	16a Dece	edent's Usual Occup	nation			16b. Kin	nd of Busin			
ה	"nat	lete	(Specify only highe	<del>-</del>		(Give	e kind of work done DO NOT use retire	during mo	st of work	ing				·	
Z	withil ene. than	Completed	Elementary/Secondary (0-12)		(1-4or 5+) 5+	I	Director of	Nursi	ng		Неа	1thca	re Se	ervices	;
מ	filed Hygi Sther ent, t		17. Father's Name (First, Middle,	Last)				18. Moth	her's Name	e (First, Middle	, Maiden S	Surname)			
land	ld be ental <b>ked c</b> ic ev	To Be	Bhuda Mall						Jiwa	n Mall					
ar S	shou ind M ind M ind M	-	19a. Informant's Name/Relations	hip (Type. Print)		1	ing Address (Street							Code)	
Z	and 2 alth a 27 ls		Ruth Haug - Dau	ghter			Amherst Av	venue,							
e)	of He of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □ Removal fro	I .	Ob. Place of Disp cemetery, cri	osition (Name of ematory or other pla	ice)		Date	20c. Lo	cation - Ci	ty or Io	wn, State	
Ĕ	Page nent ant: II		4 Donation 5 Other (5	Specify)	0		e Cemetery			8/2007	Silv	er Spr	ing,	Maryl:	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	icensee	7	٠ ١ ،	22. Name and Addre Hines-Rinale 11800 New Ha	44 Eur	oral I	Home, Inc	ver Sp	oring,	Mar	yland 2	20904
	7		23a. Part1. Enter the lisease, o shock, or heart filture. Lis	r complications that	at caused the									Approxima Interval Be	ate etween
	Physician		Immediate to se (Final disease r condition	only one oddoo o	CAR	BIOMY	OP ANY							Onset and	Deam
	/Medical		resulting in death)	Due	to (or as a co	nsequence of):	NSION								
	Examiner		Sequentially list conditions				NS10-A	9 .					-		
de	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a co	nsequence off):									
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	to (or as a go	nsequence of):									
20,	ate be executed hysician and the burial-transit	E E	Toolking in the same of the sa	Due	10 (0) as a co	risequerioe oi).									
8760	ate hy the	dical		d											
9 X	The law requires that the death certific at has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE:		outcome pf p						1 2	23d. Date	of deliv	ery	
Вох	leath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		/e birth 2 □ egnant at tim		☐Ectopic pregnand ☐Other (specify) _	су			į	Mont	th	Day	Year
P. O.	the d y the ached	ysi	9 Unknown	9□Ur	known										
٠ <u>,</u>	w requires that the d been signed by the should be detached	by Pi	Part II. Other significant condit				underlying cause gi	iven in Par	rt I.			/		the cause o	
5	quires en sig uld be	od be	DIARE	TES M	EUIN	15				1 🗆	Yes 2	No 3	3 □ Pro	bably 4	Unknown
Vital Records,	aw re s bee 2 sho	Completed								24a. Wa	s an opsy	24b. W	ere aut	opsy finding ompletion of	gs available if cause of
ž	The lav	E									formed?		eath? ∐Yes	2 □ No	
<u>ta</u>	ian: ertifica ctor, p	Be C	25. Was case referred to medic examiner?	al			2 1.		ace of Dea	th (Check only	one)				
<u> </u>	hysic his ce I dire	10	1 ☐ Yes 2☑ No			2 ER/Outpati	ent 321DOA		Nursing H	lome 5 ☐ Res				fy)	
0	Attending Physician: or death. ector: After this certification by the funeral director, it	ü	27. Manner of Death 1 Natural 5 □ Pendi	na (A	ate of Injury <i>Nonth, Day</i> Ye	ear) 28b. Time Injury	/   Wo		□No	28d. Describe	now injui	ry occurre	a		
Sio	tendi eath. tor: A	cati	2 Accident Invest	igation not be	non of injune	At home form	M 1 1 5 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2		28f. Location	(Street ar	nd Numbe	r or Bu	ral Route N	lumber.
Division or	or At after d Direc in by	Certification:		-in-ad 200, FI	uilding, etc. (S	Specify)	street, ractory, office			City or T	own, State	<del>)</del>			
_	ospital or / hours after uneral Dire ly filled in b		29a. Certifier 1. Certify	ing Physician: To	the best of m	ny knowledge, de	ath occurred at the	time, date	and place	e, and due to th	e cause(s	) and mar	ner as	stated.	20(2)
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medica	Examiner: On the	ne basis of ex nanner stated	amination and/or I.	investigation, in my			urred at the time					
	To the within	ž	29b. Signature and title of certifi	er (	16	C	1	nse numbe				-/-	/	Day, Year	
r	7		1	~ ~	, -			050						2007	
	-		30. Name and address of perso	n who completed o	cause of death	o (Item 23a) (Typ	e, Print) Ann I • Colur	Louise mbia,	Mihal MD 210	ick, M.D )44	., 575	75 Ced	ar La	ane	
	St Regist	ate trar	31. Date filed (Month, Day, Yea NOV 2	6 2007	2. Segistrar's	Signature	posts								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2003 **Physician** OF A M ant TALA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1512 Severn Chapel Rd. Crownsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 1271971951 216-48-7775 1 ☑ M 2 ☐ F 55 Mary Land Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified 1 □Yes 2 □ No Director MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1512 Severn Chapel Rd. 21032 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arnold Service Center 12 Master Tech/Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. Janice Chaney Leroy Edward Africa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 1512 Severn Chapel Rd. Crownsville, MD 21032 permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tra Jane Africa Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem Gardens 11/20/2007 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -uns una /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has page 2 autopsy 2 1∐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 tesidence 6 Other (Specify) 1 ☐ Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 1 Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hin 24 hours after death the Funeral Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 7

31. Date filed (Month, Day, Year) State NOV 2 1 2007 Registrar

29b. Signature and title of certifier

900

30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print)

Bestate Rd Sute 300 Angolo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Wal 40 M /Medical 22 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min. 213 03 2601 93 Director 1914 Maryland Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be 4818 Knoll Drive 21043 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced white er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Newspaper-Elementary/Secondary (0-12) College (1-4or 5+) tal Hygiene. Pressman of Health and Mental Hygie f item 27 Is marked other t r other traumatic event, th <u>Baltimore Sun</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Arnold ဥ Margaret Griffith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Buckmaster/daughter 4930 Alice Ave. Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State þ ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any Injury or once. Meadowridge Mem. Park 11/26/2007 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signal re o Funeral Service Lice 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pk. Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner wou Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit that the death certificate be executed and Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 000 1 Tes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Division or Vital 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 → No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 pmpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of eath 28a. Date of Injury After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending death. investigation 1 ☐ Yes 2 ☐ No Director: the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined hours after Hospital within 24 hours a To the Funeral C 1 West Tying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier BD0062022 dress of person who completed cause of death (Item 23a) (Type, Piint)

DHMH 17 Rev 1/2001

State

Registrar

44

NOV 2

31. Date filed (Month, Day, Year)

3 rown

			For State Registrar	State o	f Marylan		rtment of F		Mental Hy	giene Reg. Na 20	07	39416
	Physici /Medic		1. Decedent's Name (First, Midd Mina F. Appl						2. Date of De Month Novemb	er 24,	2000 :	3. Time of Death 9:20 A M
) 5	Examir Funeral Director		4a. Facility Name (If not institution Charelstown 5. Social Security Number 218 62 2150	6. Sex	7. Age (In yrs. I.	ast birthday) Yrs.	4b. City, Town, o  Catons  If Under 1 Year  Months Days	VIIIe  If Under 24 Hrs Hours Min	8. Date of Bi	Balt:	y of Death  IMOTE  9. Birthpla  Maily	ce (State or Foreign Yand
	ō	tor	Usual Residence of Decedent  10a. State 10b. Count		10c. City	, Town or Lo			1149.	37 1301		d. Inside City Limits
	th with the 23a or 28a- ust be notif	Funeral Director	10e. Street and Number 7009 Maiden Cho				10f. Zip Code 21228	3		10g. Citizen of USA	What Country	y?
036	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Ma  *□ Widowed 4 □ Divorce	rried Armed Fo	2 <b>₹</b> No ve	'	Vas Decedent of H f Yes, specify Cub □ Yes 2★No	lispanic Origin? (s an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		ce - Americar ack, White, et fy: Whit	c.
1215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed) College (*	1-4or 5+)	16a. Deced (Give life. I	lent's Usual Occup kind of work done OO NOT use retired	oation during most of wo d)	orking	16b. Kind of E		stry
yland 2	ould be filed Mental Hygi arked other atic event, <u>t</u>	To Be Co	17. Father's Name (First, Middle William Foster						me (First, Middle a unknow.		me)	
e, mar	1 and 2 sho Health and em 27 Is ma ther traums		Joan C. Thiele  20a. Method of Disposition		20b. P	3927	g Address (Street St. John Sition (Name of	s Lane		tt City  20c. Location	, MD	21042
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 Is marked any injury or other traumatic ev		1 Burial 2 Cremation 4 Donation 5 Other ( 21. Signature of Funeral Service	Specify)	State C	emetery, crer lent_C:	ematory or other place cematory	11/2	26/2007 erry H. 1	Hanova	er, D	ly FH INC
	Physician	- 1	23a. Part . Enter the disease, c sho k, or heart failure. Lis Immediate Cause (Final disease or condition	or contributions that controlly one cause on e	caused the death	. Do not ent	L12 OLd Cor the mode of dyin	ng, such as cardia	c or respiratory a	arrest,	1	Approximate interval Between
	/Medical Examiner	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U	(or as a consequ (or as a consequ		elle mic /	renal	Failu	re Tu	lare	4
00/00	ficate be executed physician and s the burial-transit	dical	resulting in death) Last	Due to	(or as a consequ	ience of):						
.O. 60X	the death certi y the attending ched for use a	Physician/Me	IF FEMALE: 23b. Was decedent premant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live t	tcome pf pregna birth 2 □ Fetal nant at time of de own	death 3	Ectopic pregnanc Other (specify)	у			ate of delivery onth D	/ Day Year
ecords, P	The law requires that te has been signed by age 2 should be deta	by	Part II. Other significant condit		eath but not resu			ven in Part I.		tobacco use cor	_	cause of death?
VII'al Rec	The la ate has page 2	e Completed	25. Was case referred to medic						1□ Yes	ormed?	Were autops prior to comp death? 1 Yes 2	sy findings available pletion of cause of
IVISION OF VI	ing Phy offer this uneral d	Certification: To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi	Hospital: 1 28a. Date (Mon igation not be proped 28e. Place	of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury me, farm, str	28c. Injui Wor	er: 4 Nursing	28f. Location		rred	
ב	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Cer	29a. Certifier	ng Physician: To the I Examiner: On the b and man	e best of my know asis of examinat ner stated.	wledge, death ion and/or in	occurred at the ti	me, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) and n	nanner as sta , and due to t	ted. the cause(s)
)	To th within To th сопрі	Me	29b. Signature and title of certifi		. /	MAI	29c. Licens Print)  Chia	e number	5	29d. Date sign	ed (Month, Di	ay, Year)
3)	Q2 Sta	ıta.	30. Name and address of person 31. Date filed (Month, Day, Year	110 11	1 Ma	eden	Print) alias	ee Can	e, Car	lémica	llg,	40
DHI	Registr MH 17 Bev 1/2	ar	31. Date filed (Month, Day, Year NOV 2	6 2007	de Strar's Signat	J. A.	barle					

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State of Mar		artment rtificate			ind M	Re	g. No. U U	7	39417
	Physic /Medi	cal		amil	Brown	45 000	<u> </u>	1 6		2. Date of Death	2007		3. Time of Death 12:10a M
	Exami	ner	4a. Facility Name (If not institution, given Holy Cross Holy Social Security Number 6. S	spital	In yrs. last birthday)		Lver	Location of Spr	ing	8. Date of Birth	4c. County of	gome	ry ace (State or Foreign
	Funeral Director			2□F // 2□F	Yrs.	Months	Days	Hours 8	<b>4</b> ⁴7	1 1 / 20	2007	Mar	y) yland
	e Marylan 3e-f show tiffed et	ctor	10a. State 10b. County MD Montgon		oc. City, Town or Lo Silver		ng					100	d. Inside City Limits 1 ☐ Yes 2 1 No
	ath with the 23a or 24	<b>Funeral Director</b>	10e. Street and Number 3309 Parkford			10f. Zip	209				g. Citizen of W USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other treumatic event. The Medical Evant activities is untilled at Once.	by Fune	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decede If Yes, speci 1  Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	Black	- Americar , White, et Blac	c.
Baltimore, Maryland 21215-0036	within 72 ho ane. than "netur ne Medical.	To Be Completed by	15. Decedent's Ec (Specify only highest gra		16a. Dece (Give lite.	dent's Usual kind of work DO NOT use	Occupa k done d e retired)	ition uring most	of workin	ng 10	6b. Kind of Bus	iness/Indu	stry
/land 2	uld be fited Mental Hygir irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Jermaine Brow	n	110	116				(First, Middle, Ma	aiden Sumame		
, mary	and 2 sho saith and h n 27 is ma er treums	1	19a. Informant's Name/Relationship (1 Candis William		19b. Mailir 3309	ng Address Park	Street a	nd Number	or Rura	Route Number, Ce Apt.	C Sil	ver	Spring M
imore	Pages 1 ment of He ent: If iten lury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Remova from State	20b. Place of Dispo cemetery, crer Chesape	natory or oth	ner place	" <b>1</b> 1		/2007	Belts	ity or Town $ extstyle  ex$	20904 n, State e, Md.
Ball	permit Depart Import any inj		21. Signature Huneral Service Liber	inell.	9	241 (	Colu	ımbia	Bl		er Sp		,P.A. ,Md20910
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or companies to the companies of the compan	one cause on each line.	turity	er tile mode	or dying	, such as c	ardiac of	respiratory arres	ι,	Ir	Approximate nterval Between Onset and Death
9,00,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):								
O. BOX O	requires that the death certifica een signed by the attending phould be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pre Other (spe					23d. Date Mont	,	ay Year
r (Sp.	w requires that been signed t should be det	by	Part II. Other significant conditions of	entributing to death but n	ot resulting in the ur	nderlying car	use give	n in Part I.					cause of death?
	The law ate has b page 2 sl	Completed	pl							24a. Was an autopsy performe	d? de	ath?	y findings available letion of cause of
_	nding Physician: 1 ath. r: After this certificat e funeral director, p	atlon; To Be	25. Was case referred to medical examinar?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Manpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury		Other	4 🗆 Nurs	sing Hom 2	(Check only one) ne 5  Resident 8d. Describe how			
DISION	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (S	Specify)					8f. Location (Stre City or Town,	State)		
	the Hosp nin 24 hou the Fune npletely fil	Medical	one) 2 Medical Exam	rsician: To the best of miner: On the basis of exa	amination and/or inv	estigation, i	n my opi	nion, death	place, ar occurre	d at the time, date	and place, an	d due to th	ie cause(s)
	To To	Σ	29b. Signature and title of certifier	866_			License	S965	3		Nov.21		
	Cha	•	30. Name and address of person who can and address Block 31. Date filed (Month, Day, Year)		Forest		Roa	d Si	lve:	r Sprin	g,Md 2	2091	0
	Sta Registr		NOV 2 6 200		H And	rate o							

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate o			ene 2007	39418
	Division		1. Decedent's Name (First, Middle, I	Last)				2. Date of Death Month	n Day Year	3. Time of Death
	Physici /Medio		Cameryn Jai	rred B	rown			Nov.20	,2007	11:30ង
4	Examin	er	4a. Facility Name (If not institution, g			776	n, or Location of De		4c. County of Dea	
			Holy Cross Ho				er Spri		Montgo	
	Funeral		5. Social Security Number 6 none	. Sex 7. Ag 1 🛣 M 2 🗆 F	e (In yrs. last birthday, Үгs.	Months Day		Irs. 8. Date of Birth Month Day, 10 1 / 20	72007 Mar	thplece (State or Foreign Cyland
	Director		Usual Residence of Decedent					10 11/20/	200, 1102	7 - 4 - 1
	/land		10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	Man,	ţ	MD Montgo	omery	Silver	Spring				1 ☐ Yes 2 No
	n the	Director	10e. Street and Number		Apt.C	10f. Zip Code		10	g. Citizen of What Co	ountry?
	th wit	a D	3309 Parkford	d Manor To	errace		20904		USA	
	ems dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of	of Hispanic Origin?	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit	
36	or it	y F	1 XNever Married 2 Married	If Yes, Give	No	1 ☐ Yes 2 🖾 N			Specify: F	Black
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28e-f show Ita Medical Examiner mant be mullisad at	Completed by Funeral	3 Widowed 4 Divorced	Year or Dates:	100 David	d- who like all On				
15-	"nat	iete	15. Decedent's (Specify only highest	grade completed)	(Give	edent's Usual Oct e kind of work do: DO NOT use ret	cupation ne during most of i ired)	working	16b. Kind of Business	midustry
12	withi then	E C	Elementary/Secondary (0-12)	College (1-4or 5	5+)	one			none	
9	filled Hygid Sther ent, I		17. Father's Name (First, Middle, La	st)				Name (First, Middle, A		
lan	should be filed within of Mental Hygiene. marked other than imatic event, IL a M	To Be	Jermaine Brow	√n			Cand	lis Willi	ams	
<u></u>			19a. Informant's Name/Relationship					Rural Route Number,		
	1 and 2 Health a em 27 la		Candis Willia	ams/Mother	r 330	9 Park	ford Ma	nor Terr	ace Apt.	C Silver
ore.	of He of He ritem		20a. Method of Disposition  1  Burial 2  Cremation 3	□RomeOnl from State	20b. Place of Disp cemetery, cre	matory or other p	olace)		20c. Location City or	
Ĕ	Pages nent of I ant: If it		'4 □Donation 5 □ Other (Spe		Chesap	eake Cı	rem. 111	/24/2007	Beltsvil	le,Md
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr 2000.		21. Signature Funeral Service bio	contrary M	ı	PHITE INPAd	os rinal	DI FUNER	AL SERVI	CE,P.A.
ш_	40 E S 9	1, 11	/ my /	unto						ng.Md20910
			23a. Part1. Enter the disease, or co shock, or hear failure. List or	emplications that caused by one cause on each li	the death. Do not en ne.	iter the mode of o	tying, such as card	diac or respiratory arre	est,	Approximate Interval Between Onset and Death
	nysician	1 0	Immediate Cause (Final disease or condition	_a. Pr	ematurity	7				
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	ä				
н		_	Sequentially list conditions,	b. — Due to /or as	a consequence of):					
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury)	540 (5) 45	a consequence siy.					
	axecu al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):		<del></del>			
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	licai Examine		Ч						
89	ificat g phy as the	9								
Вох	eath certifica attending ph I for use as th	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregna	DCV.		23d. Date of de	
B	ie deati the atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
P.0	that the d ed by the detached	h Y	9 Unknown							d
S,	res tha igned be de	þ	Part II. Other significant condition:	s contributing to death b	ut not resulting in the	underlying cause	given in Part I.		acco use contribute to	
ord	w requir been si should	ted						- 1 1	s 2XCNo 3∏P	robably 4 Unknown
of Vital Records,	hasb ge 2 st	Completed						24a. Was an	v prior to	utopsy findings available completion of cause of
<u>=</u>	pa ate	Sol						perform 1 Tes 2	ned? death? ☑No 1 ☐ Yes	2 □ No
Vita	ticien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Death (Check only on		
of	Physicien: r this certific ral director,	၉	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1 🖾 Inpatie			1 □ Nursing	g Home 5 Reside	nce 6 Other (Spe w injury occurred	cify)
	ding I h. After funer	io	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury	V	Nork? □ Yes 2 □ No	200. 2000120 110	w injury cocurred	
Division	or Attending after death. Director: After in by the fune	lical	3 Suicide 6 Could no	be age Blace of Ini	ury - At home, farm, s				reet and Number or R	ural Route Number,
÷	after after Direct	Certification;	4  Homicide determine	building, et	c. (Specity)			City or Town	, State)	
	To the Hospitel or Attending Physicien: within 24 hours atter death:  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, dea	th occurred at the	e time, date and pla	ace, and due to the ca	use(s) and manner a	s stated.
	he Ho in 24 he Fu pletel	edicai	one)	aminer: On the basis o and manner st	ated.					
	Yeith To t	Σ	29b. Signature and title of certifier	018		29c. Lice	ense number		od. Date signed (Mon. Nov. 21,	
•				-DW			39657	7	1100.21,	2007
			30. Name and address of person with Andrew Block		Forest C		C+1 170	r Chrin-	MA 2001	0
	-						· PIIA6	r spring	, Ma 2031	0
	Sta Registr		31. Date filed (Month, Day, Year)	2007	ar's Signature	perti				

07-09055 Mic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Benedict	1-	State of Maryland / Department of Health and Mental Hy For State		g. No. 20	07 3941
Physician		egistrar Decedent's Name (First, Middle,Last)	Date of Death     Month		3. Time of Death 0915 hrs
Medical Examin	er	Michael John Benedict	November	23, 2007 4c. County of Death	
	4	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  West Friendship	1	Montgomery	
		Rt. 97	8 Date of Birt	h/MM/DD/YYYYY 9. Bir	thplace (State or Foreign
Funeral Director	1	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	_	.6, 1953 II	ountry) linois
	H	Isual Residence of Decedent			10d. Inside City Limits
апу	- 1	0a. State 10b. County 10c. City, Town or Location			1 Yes 2 X No
nd show	5	Maryland Montgomery Gaithersburg		0g. Citizen of What Cou	
re Maryland or 28a-f show		0e. Street and Number 10f. Zip Code 20877	[ ''	United S	ľ
ith the A		142 Was Decedent Ever in LLS 13 Was Decedent of Hispanic Origin? (S	Specify Yes or No	- 14. Race - Ame	rican Indian, Black,
ath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	
er de		3 Wildowed 4 X Divorced If Yes, Giva Year 1 Yes 2 X No specify:		Specify:	White
irs aft	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	work done	16b. Kind of Business	/Industry
2 hot	iğ.	Elementary/Secondary (0-12)  College (1-4 or 5+)  Sales Associate	itil Ca)	Manageme	nt
136 thin 7 than than	린				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	e Completed	17. Father's Name (First, Middle, Last)  Louis Benedict  18. Mother's Nam  Dori	ne (First, Middle, .s R <b>ynk</b> 16	Maiden Surname)	
212 ould be Menta marke	o Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or			
MD 2 id 2 show lith and N m 27 is n aumatic	-	19a. Informant's Name/Relationship (Type, Print ) Gloria M. Benedict/ Former spouse 19b. Mailing Address (Street and Number or 2108 N.W. Eighth Str	eet, Blu	ue Springs,	MO 64015
and 2 and 2 ealth tem 2 traun	1	20b. Place of Disposition (Name of cemetery,	Date vember	20c. Location - City of	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr		1 Burial 2 Cremation 3 Removal from State Metropolitan	, 2007	Alexandri	a, Virginia
tim E. Pag tment rtant:		4 Donation 5 Other Seecify: CTEMECOLY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility D			
Bal Sermi Depar Injur		10 E. Deer Park D	rive, Ga	aithersburg	
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory ar	rrest, shock, or heart	Approximate Interval Between Onset and
Physician / / / / / / / / / / / / / / / / / / /					Death
aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b.			
	Jer	if any, leading to immediate Due to (or as a consequence of):			
Q <sub>2</sub>	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated  c.  Due to (or as a consequence of):			
P ed P		events resulting in death) Last			
i0,  e be executed ysician and burial - transit	dical	UNPENDED AMENDED			
50, te be iysicis		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	-
ords, P.O. Box 68760 v requires that the death certificate s been signed by the attending phys should be detached for use as the b	Physician/Me	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	Month	Day Year
X 6 th cer ttendi	icia	4 Pregnant at time of death 5 Other (Specify)			
Box e death of the atter	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
O. hat th ed by letach	by P	Part II. Other significant conditions commoding to death but not resolving in the shading in the	1Y	res 2 ✔ No 3 F	Probably 4 Unknown
S, P nires th n signe d be d			24a. Wa	as an 24b. Were	autopsy findings available
of Vital Records, ng Physician: The law require ther this certificate has been si nneral director, page 2 should b	Completed			topsy prior rformed? death	to completion of cause of
tal Recolerant: The law	E		1 🗸 Yes		Yes 2 No
tal R cian: T certifica ector, pa		25. Was case referred to medical 26.Place of Death (Che			
Vita hysicia this ce	o Be	1 Ves 2 No	irsing Home 5	Residence 6 🗸 O	ther: Scene
Ing Phy After th	⊢	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	Subject h	oe how injury occurred anged self	
ion (rendin eath or: A	힐	Nov 23, 2007 0900 hrs			
Division In or Attendir Is after death al Director: /	ig i	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town	n (Street and Number o n, State)	r Rural Route Number, City
Divisi pital or At ours after d ceral Direct filled in by	Certification:	determined (Specify) Interstate/Express (RVIX()		n, State) st Friendship, MD	
	Į Š	20a Certifier	and due to the c	ause(s) and manner as	stated.
To the Hos within 24 h To the Fur	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr	ed at the time, da	ate and place, and ode	10 110 04100(-7
	ĕ	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
V		O.C.M.E.		November 24	, 200 <i>1</i>
		30. Name and address of person who completed cause of death (Item 23a)			
		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	Stat	31. Date filed (North Party Party) 2003 37 Registrar's Signature			
Regi		31. Date filed (NOTO) 22 6 2007 Mayor B April 2007			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BARBER Physician Month /Medical 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Chesapeake Hospice Harwood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 ▼ F Yrs. 93 Director 577-16-4262 4/19/1914 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Ex-miner must be notified at 1 ☐ Yes 2√ No Director Crownsville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21032 USA 603 Simms Landing Rd Funeral 2 should be filed within 72 hours after death and Mental Hygiene. is marked other than "natural", or items 23: aumatic event, the Medical Eximiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 23X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2CXNo Specify 2 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item Z7 is marked any linjury or other traumatic evonce. William Brown Lucy Woodland ည 19a. Informant's Name/Relationship (Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine L.B. Burdette 603 Simms Landing Rd, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 11/19/2007 Falls Church, VA 21. Signature of Fundal Service Licensee 22. Name and Address of Facility National Funeral Home 7482 Lee Hyw, Falls Church, Virginia 22042 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only on Approximate Interval Between Onset and Death 4 Leur tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE. nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐Yes 20☐No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ 2 □ No 24a. Was an has autopsy 1\_ Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Residence 10 Residence 10 Nursing Hospice 2 No 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) NOV 2 6 2007

Name and address of per

441

on who completed cause of death (Item 23a) (Type Print)

M im

FONSE HIGHWAY ANNAPOUS MO LIGO, 32 Registrar's Signature

		1 State		rtment of Health and N tificate of Death		ene k <sup>No.</sup> o o o o o o o o o o								
	49	Registrar  1. Decedent's Name (First, Middle, Last)		mode or boats	2. Date of Death	200 3 Jimp of the attr								
Physic /Med		James A. Bacon			November	24, 2007 8:44 рм								
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death								
Funera Director		217-70-3216 1 <sup>™</sup> M 2□F	n yrs. last birthday) 51 Yrs.	Silver Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Nov • 27,	Montgomery 9. Birthplace (State or Foreign Country) 1955 Washington, DC								
and		Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or Loc	cation		10d. Inside City Limits								
Maryl. f sho	jo	Maryland Montgomery	Silve	r Spring		1 ☐ Yes <b>¾</b> ☐ No								
h the r 28a r notii	irec	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Country?								
th wit 23a o 1st be	al D	4006 Sampson Road		20906		USA								
III (A E I & I 3-UU30  be filed within 72 hours after death with the Maryland ntal Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married  2 ★ Married  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Nas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert I ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify. Thite								
ed within 72 hours af gjene. er than "natural", or the Medical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life, L	lent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	6b. Kind of Business/Industry								
filed wi Hygien ther the	S	9		Heavy Equipment	Operator ne (First, Middle, Ma	Construction								
nd 2 should be filed w Ifth and Mental Hygie 27 is marked other tr	Be	17. Father's Name (First, Middle, Last)  James B. Bacon			C. Mandle									
s 1 and 2 should f Health and Men item 27 is marke other traumatic	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Number or Ru	-									
d 2 d 2 th a tra	1 8	Donna Jean Bacon/Wife	I	•		Spring, MD 20906								
permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	-	tan Crematory Nov	y. 30,	Oc. Location - City or Town, State								
permit. Departm Importal any inju		21. Signature of Funeral Service Licensee		Name and Address of Facility rancis J. Collins	s Funeral									
Physician		23a. Part1. Entay the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Hepatorenal Failure												
/Medical		Due to (or as a co	onsequence of):											
ificate be executed if physician and its the burial-transit	al Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. METASTA  Jun b. (ur and or continue)  c	onsequence of):	Cell Lung Cancer										
law requires that the death certificate as been signed by the attending physic should be detached for use as the	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  d.  23c. If yes, outcome pf of the past 12 months? 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year								
ss tha	by P	Part II. Other significant conditions contributing to death but n				acco use contribute to the cause of death?								
w requires to been signer should be		Hepatic Encephalopathy, Panc	reatitis,	Respiratory Fai	lure 1xx <sup>Yes</sup>	s 2 No 3 Probably 4 Unknow								
The ate har page	Completed				24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of death?								
Physician: r this certificanal director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Nonatient	2 ☐ ER/Outpatien		ath (Check only one									
Phy r this eral d	2	27. Manner of Death 28a. Date of Injury	28b. Time of	f 28c. Injury at Work?	28d. Describe hov	nce 6 Other (Specify) w injury occurred								
Il or Attending Ph after death. Director: After th d in by the funeral	tior	1. Natural 5 ☐ Pending (Month, Day Yo 2 ☐ Accident investigation												
al or Attence at Safter death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (3	- At home, farm, str Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)								
To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edical (	29a. Certifier (Check only one)  TE Certifying Physician: To the best of n  2 Medical Examiner: On the basis of examiner stated	camination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)								
To the H within 24 To the F complete	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, Day, Year)								
8		30. Name and address of person who completed cause of death	M.D. th (Item 23a) (Type,	D64100		November 25, 2007								
	1			en Road, Silver	Spring, M	D 20910								
S Regis	tate	31. Date filed (Month, Day, Year) 32. Sigistrar's	Signature	naut 1										

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Cei	rtificate of Dea	ith	F	Reg. No.				
	Physici	an a	1. Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	ath Day	20 Mar7	3/TimeofDean		
	/Medic		Robert	Herman	Buckle				er 2	2, 2007	7:25 AM		
7	Examin	er	4a. Facility Name (If not institution			4b. City, Town, or Locat			4c. C	County of Death			
			5. Social Security Number	Nursing Center	rs. last birthday)	Prince 1	Freder:		<u></u>	Calvert	lace (State or Foreign		
	Funeral Director		220-34-4823	1X M 2□ F 78	Yrs.	Months Days Hou		8. Date of Birtl (Month, Day 01-20-	1929	Mary	rland		
	land t		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits		
d Z1Z15-0036	Mary -f sho fied a	tor	MD Calv	ert		Prince 1	Freder:	ick			1 ☐ Yes 2 XNo		
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	itry?		
	th wit	a D	5955 Macs Holl	ow Road		20678				USA			
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	u.s. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	. 1	4. Race - Americ Black, White,			
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ð	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced			1⊡Yes 2 <b>X</b> No <i>Spe</i>		,		Specify: whi			
2	72 hd 'natu dicai	etec	15. Deceden (Specify only higher	t's Education st grade completed)	16a. Deced	dent's Usual Occupation kind of work done during DO NOT use retired)	most of worki	ing	16b. Kin	d of Business/Inc	dustry		
7	vithin ne. han " e Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)									
7	e filed v al Hygie I <b>other t</b> vent, th		12 17. Father's Name ( <i>First, Middle,</i>	(ast)	neav	y equipment		(First, Middle,		avating			
and	2 should be finance and Mental His marked ot raumatic ever	) Be	James Arthur			10.16	Myrtie		marden		ward		
<u></u>	should od Me mark matk	ပ	19a. Informant's Name/Relations		19b. Mailir	ig Address (Street and Nu			er. City or				
	and 2 sealth an m 27 is		Patrick Buckle	r. nephew		Donna Lane					,		
Baltimore,	s 1 a of Hea Item		20a. Method of Disposition	201		sition (Name of matory or other place)	•	Date	•	ation - City or To	wn, State		
	Page nent c int: If iry or		1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Memoval from State	Vesley C		11-2	7-2007	Prir	nce Fred	erick, MD		
	permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other tonce.		21. Signature of Funeral Service	Licensee		2. Name and Address of F			neral	L Home,	P.A.		
			23a. Part1. Enter the disease, or	complications that caused the de		-				, FED 200	Approximate		
	Physician		Immediate Cause (Final	only one cause on each line.	enti:						Interval Between Onset and Death		
*	/Medical		disease or condition resulting in death)	Due to (or as a cons	777								
	Examiner		Sequentially list conditions, b. Typer tersion										
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	. ,	0 () 1							
	and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons		12/1/us							
08/00,	certificate be executed iding physician and ise as the burial-transit			1 200 to (or do d oor)	oquonico oi).								
00	ficate phys s the	Medical		d									
XOD	n certific inding p use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre-					23	3d. Date of delive	ery		
	death e atten ed for u	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ F 4 □ Pregnant at time o		Ectopic pregnancy Other (specify)				Month	Day Year		
5	at the by th tache	hys	9 Unknown	9□Unknown									
'n	w requires that the death cer been signed by the attendir should be detached for use	by F	Part II. Other significant condition	ons contributing to death but not	resulting in the ur	nderlying cause given in P	Part I.				ne cause of death?		
ecords,	requi	ted						1 L Y	′es 2□	No 3☐ Prob	ably 4 Unknown		
ກັ	The law tte has b	Completed						24a. Was a autop	sy	prior to co	psy findings available npletion of cause of		
	r: Th cate pag								med? 2 No	death? 1 ☐ Yes	211No		
N II G	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oak	-	(Check only or					
5	Phys	۲. <u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien	I SLI DOA		me 5 ☐ Resid 28d. Describe h		Other (Specif	γ)		
5	ding F th. : After s funer	tion	Natural 5 ☐ Pendin 2 ☐ Accident investig	q (Month, Day Year		28c. Injury at Work?  M 1 Yes		-04. 2000201.		00041104			
VISIOII	ospital or Attendi hours after death. uneral Director: A ly filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could in 4 ☐ Homicide determ	ined   28e. Place of Injury - A	t home, farm, str	eet, factory, office				Number or Rura	l Route Number,		
5	s afte al Dir ed in	Cert	4 I Hornicide	building, etc. (Spe	city)			City or Tow	m, State)				
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier / Certifyir (Check only one) 2 Medical	ng Physician: To the best of my l Examiner: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	n occurred at the time, dat vestigation, in my opinion	te and place, , death occur	and due to the ored at the time,	cause(s) a date end p	and manner as s place, and due to	tated. the cause(s)		
	To th To th COMP	Me	29b. Signature and title of certifie	r		29c. License numb	1	2	29d. Date	signed (Month,	Day, Year)		
•			>//n	M		D006	194	7	11/	126/0	7		
011	) ,		30. Name and address of person	who completed cause of death (I	0 0	Print)		-					
K)	6		Mans, Mathy	MD 110 HOSO	ital Roc	1 #305 7	nnut	redench	L'WI	20678			
	Sta Registr		31. Date filed (Month, Day, Year)	2 6 2007	gnature /K	Snack D							

	1	For State Registrar	State of Marylan	•	te of Deat	h	Reg. N	-001	39423	
Physician /Medical	1	1. Decedent's Name (First, Middle, Last) Robert Bre	eslau			2.	11 -21 -	ay Year - 2007	3. Time of Death	
Examiner		ta. Facility Name (If not institution, give st		ke Sa		er 24 Hrs. 8.		C. County of Death  O CO (T)  9. Birthpla  County	ace (State or Foreigny)	
Director		027-38-1497   1X   Usual Residence of Decedent  10a, State   10b, County		chusetts  od. Inside City Limit						
215-0036 hin 72 hours after death with the Marylan b. in "natural", or items 23a or 28a-f show Medical Examaner must be notified at		Maryland Wicomico		y, Town or Location  lisbury	Lip Code		10a. C	Citizen of What Count	1 XYes 2 N	
th with	2	5508 St. Andrews	Drive		21804			USA		
d 21215-0036 Ilied within 72 hours after death with the Maryland Hygiene. Uther than "natural", or Items 23a or 28s-1 show ant, the Medical Examanar must be notified at a Completed by Financial Director	2	11. Marital Status  1 ☐ Never Ma <i>m</i> ed 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		edent of Hispanic ( ecify Cuban, Mexic 2 X No Speci		ly Yes or No- can, etc.)	14. Race - America Black, White, e Specify: W		
21215-0036 ed within 72 hours all giglene. iver than "natural", or the Medical Exprir. it, the Medical Exprir.	nbieren	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)		vork done during m use retired)	ost of working		Kind of Business/Ind		
d 21	ו ע	12 17. Father's Name (First, Middle, Last)	4+	vice pre		ther's Name (i	First, Middle, Maide	erdue Farm en Sumame)	ns	
should be not Mental or marked o	0	Maxwell Breslau				stelle		Town Chats Tim	Ondal	
y, Maryland and 2 should be fill balth and Mental Hy n 27 is marked oth ref traumatic avan		19a. Informant's Name/Relationship (Type Carol Breslau/wife						City or Town, State, Zip Code) TY, MD 21804		
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic avant, training.		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disposition (Nemetery, crematory of	r other place)	Dat 11/23		Location - City or Tovallisbury,		
Baltin permit. I Departm Importe any inju	ľ	21. Signature of Funeral Service License  22. Signature of Funeral Service License  23. Part I. Enter the disease, or complic shock, or heart failure. List only one	re- (FSB)	<sup>22</sup> H811 501	and Address of Fa Oway Fund Snow Hil	eral Ho	me Profe Salisbur	ssional As y, MD 2180		
Carlot Examiner transit to build Examiner to build Examiner to build Examiner transit to build Examiner transit to build Examiner transit to build Examiner transit to build Examine to build Exa	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last	Due to (or as a consecutive to (or a))).	quence of):	OPMAGE.	He c	îAR CIN	10 mA		
	Physician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23d. Date of delive Month	ry Day Year						
dS, P	2	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	g cause given in Pa	irt I.	23e. Did tobacc	o use contribute to th	e cause of death?	
Division of Vital Records, I or Attending Physicien: The law requires the affer death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be death.	Completed						24a. Was an autopsy performed 1 Yes 2 🔼	?   death?	psy findings availant pletion of cause	
f Vital Reysicion: The director, page	o ne	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ER/Outpatient 3□	Other		Check only one) e 5 ☐ Residence	6 ☐Other (Specify	()	
ision of the the think of the funeral of the funera	- 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	jury occurred							
- 5956	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At h building, etc. (Speci	·fy)			City or Town, St			
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one)  Certifying Physical Examination	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date ion, in my opinion,	and place, and death occurred	d due to the cause d at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)	
To the within To the comple	Be	29b. Signature and title of certifier			29c. License numb		1	Date signed (Month,		
1821		30. Name and address of person who co		m Zda (Type, Print)	10005	34110	>   //	1-21-6	/	
State	<b>e</b>	GHULAM WARES	COASTAL T	tospicia	H BOX	1733	SALIS	BURY	40 2180	

Rodney Clevelan			St	ate of Maryla		partme	ent of	Health			•	jiene	gibic.			
		I- For State Registrar	- /Final Balalal	(a.l4)	С	ertifica	ate of	Death			10	Ro Date of Dea	eg. No.	200	7	3942
Physicia Medical Examir		1. Decedent's Name Rodnev		and Bound	S						2.	Month Novembe	n Day r 19, 200	Year )7	3. Time of 1402	
E.		4a. Facility Name (i	f not institution	on, give street and nu			41	o. City, Tow		ocation of			4c. Co	ounty of Dear	h	
Funeral		7444 Quepo 5. Social Security N		6. Sex	7. Age (In yrs	s last hirt	hday)	Newark		If Under	24Hrs	8. Date of Bir			rthplace (St	ate or
Director		218-12-		1X M 2 F	i Aige (iii yit	88	Yrs.		Days	Hours	Min	March	`	Fore	gn	MD
		Usual Residence of	Decedent			-		l		L	Ll	TIGI CII	20, 12	717		
ow any		10a. State	10b. County		10c. C	•	or Locatio	n								e City Limits
Maryland 28a-f show d at once.	Director	MD 10e. Street and Nu		cester		Newa	ark	10f. Zip Co	ode			1	0g. Citizen	of What Co		3 2 2 110
1215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.		7446 Qu	eponco	Road				21	841				U.S.A			
h with	Funeral	11. Marital Status		12. Was Dec	cedent Ever in	U.S.		Decedent s, specify (				cify Yes or No	- 14.	Race - Ame	rican Indian	, Black,
er deat		1 Never Marrie	_	arried Armed F 1 Yes vorced If Yes, Give Yes	2 X No			Yes 2 X			donto i d	cuit, ctc.,	Cod			
ours aft ntural"	d b			or Dates:		) 16a.	Decedent'	s Usual Oc	cupatio	n (Give ki				ec <i>ify:</i> d of Business	white/Industry	
6 172 ho an "na	lete	Elementary/Seco	ondary (0-12)	College (	1-4 or 5+)		during mo	st of workin	ıg life. D	OO NOT u	se retire	d)				
OO3 withir per the Medi	Completed	12 17. Father's Name	/Eiret Middle	Last			Fa	rmer	119	R Mother's	Name (	irst, Middle,	Grai	n, Da	Lry, P	oultry
215- e filed ital Hy ked of				•	s. Sr.					Bess			Waldell Sul	mame,		
MD 21215-0036 d 2 should be filed within 7 d and Mental Hygiene. In 27 is marked other than summatic event, the Medica	리	19a. Informant's Na	me/Relations	and Bound ship (Type, Print)	<u></u>				(Street	and Numb	er or Ru	ral Route Nur		or Town, Sta	te, Zip Code	)
and 2 sealth are 27	-	Paul Bo		(Son)	20	b. Place o	of Disposit	Mason				erlin, Date		21811 ation - City o	or Town, Sta	te
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2	Cremation	n 3 Removal f	om State T	cremat rinii	ory or othe Ly Ga	er place) rden s								
altin mit. P partme portan ury or	ŀ	4 Donation 5 21. Signature of Fu			[0]	i Mer	22. Na	me and Ad	dress o	of Facility		23, 20			Mary	land
<b>9</b> 7 7 1 5		. /	Cues				Sh   13	ort East	une Gr	ral l	dome Stre	et De	lmar,	DE 1	19940	
Physician /Medical		23a. Part I. Enter f failure List on	ne disease, or ly one cause	complications that con each line.	aused the dea	otgun	wound	of d	dying, si <b>nest</b>	uch as cai	rdiac or r	espiratory an	rest, shock,	, or heart	Betwee	mate Interval on Onset and Death
aminer		Immediate Cause ( or condition resulti		Due to (or as			Chest								-	Destil
	١	Sequentially list co		b												
	Examiner	if any, leading to in cause. Enter Under (Disease or injury to	erlying Cause	C												
uted d ansit		events resulting in		Due to (or as a	consequenc	e of):										
0, be executed sician and ourial - transit	dical	UNPENDED		7	erME.g87	/ <sub>1</sub> 12	/27/07	יויוי								
760 ficate b g physi the bu	/Me	IF FEMALE: 23b. Was decedent	pregnant in t	23c. If yes,	outcome of p					7=				Date of delive	•	V
Box 6876( e death certificate the attending phy.	sician/Me	past 12 months	\$?	4 Preg	οιπη nant at time of			aldeath er <i>(Specif</i> )	) )	Ectopic	pregnan	су	Mic	onth	Day	Year
. Bo he deat y the at	Phys	1 Yes 2		9 Unki	own	-4 141-	- 1- 41	- d - d. (		i- D		Togo Did	obassa usa	e contribute	a the equipe	of death?
Records, P.O. Box 68760 The law requires that the death certificate I icate has been signed by the attending phys page 2 should be deached for use as the bi	ē	Part II. Other signi	incant condi	dons contributing t	o death but no	ot resultin	g in the ur	idenying ca	ause giv	ven in Pan	ι .		processor.	io 3 Pr		
rds, require been si	Completed							2. 2.		_		24a. Was				ings available
Reco The law cate has	dwo												ormed?	death?	,	of cause of
tal Rection: The certificate ector, page	Be C	25. Was case refer examiner?	red to medica					26		of Death (	Check or					
f Vit	P	1 Ves  27. Manner of Dear	2 No	Hospital: 1	Inpatient 2		utpatient Time of In			other <sub>4</sub>		Home 5		e 6 🗸 Oth	er: Scene	
Division of Vital Records, pital or Attending Physician: The law requirents after death.  eral Director: After this certificate has been sifilled in by the funeral director, page 2 should by	Certification:	1 Natural	5 Pen	ding Nov 19	of Injury h, Day Yeer) , 2007		0 hrs	july   201		es 2 🗸	S	ubject she		occurred		
ivisior  I or Attend after death Director:	ifica	2 Accident 3 ✓ Suicide		stigation 28e. Place	ce of Injury - A	At home, fa	arm, stree	t, factory, o	ffice bu	ilding, etc	. 2			Number or I	Rural Route	Number, City
.면 음 를 드	Cert	4 Homicide			Farm/Ra	anch					7.	or Town, 444 Quepor	nco Road,	Newark, N	/ID	
= 2 E 5	Medical	29a. Certifier 1 (Check only one) 2		hysician: To the be miner:On the basis	of examinatio											)
To the within To the comple	Me	29b. Signature and	title of cettifi	and manner	stated.			29c. l	icense	number			29d. Dat	te signed (A	fonth, Day, Y	'ear)
		120	2 f 11	leul				(	O.C.M	1.E.			Nover	mber 20,	2007	
1381	ı			who completed cau			1 Penn	Street, E	Raltim	ore Mr	7 2120	1		· · · · ·	<del></del>	
	ate	Laron Lock		Assistant Medica	egistrar's Sign		-		Jaiuiii	OIE, IVIL	. Z 1ZU	1		<u>.</u>		
Regist		1	UV NO	2007	ogistrar's Sign	D.	600	de								

DHMH 17 Rev 1/2001

ORIGIN

DOME

		1	For State Registrar	State of Mary		artment of F			ene 007	39425	
	Physicia	_	1. Decedent's Name (First, Middle, Las	1 1	-	BA66	· C	2. Date of Death Month	Day Year	3. Time of Death	
S	/Medic		4a. Facility Name (If not institution, give				r Location of Deatl	NOVEMB	4c. County of Deat	/ /	
\$ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Examin	C1	Anne Arundel Medic				apolis		Anne Aru	nde1	
	Funeral		5. Social Security Number 6. So	ex 7. Age (In	yrs. last birthday)		If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Birt	hplace (State or Foreign	
À	Director	_	172-24-9014	M 2□ F	75 Yrs.	Monard Bays		4/28/19	932	PA	
	and **	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits	
	Maryl f sho jed s	0	MD Anne Art	ınde1	Annapo	lis				1 ⊟Yes 20 <b>€0</b> Nio	
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?	
	23a o	a D	7 Tuckers St.			2	21401		USA		
	ems erms	iner	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit		
36	s afte	by Fu	1 ☐ Never Married <b>※</b> Married 3 ☐ Widowed 4 ☐ Divorced	MXYes 2 ☐ No 1 If Yes, Give Year or Dates: 1	950 <b>-</b> 955	1 ☐ Yes 2€XNo	Specity:		Specify:	USA	
21215-0036	hour		15. Decedent's Ed	lucation	16a. Dece	ident's Usual Occup			6b. Kind of Business	/Industry	
215	72 nic 72	piet	(Specify only highest gra	de completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	rking			
212	giene gretha	Completed	Zionionary/occordary (o 12)	5+		Officer			US Navy		
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Items 23s or 28s-f show eumstic event, the Medical Exam art must be indified at	3e	17. Father's Name (First, Middle, Last)					me (First, Middle, M			
<u> </u>	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any Injury or other treumatic evones.	ပို	Andrew H. Baggs	T 0:0	105 14-11	Add /Cassa		Marie Don	City or Town, State,	Zio Code)	
Mar	12 sh th and 7 le m treum		19a. Informant's Name/Relationship (19bra Baggs Wife			-		olis, MD 2		Lip Cooey	
ė,	1 and Healt em 2	-	20a. Method of Disposition		20b. Place of Disp	osition (Name of			20c. Location - City or	Town, State	
altimore,	ages ant of tt: If It		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory or other pla ns Cemete	11/	28/2007	Crownsvill	e. MD	
alti.	mit. F partme corten Injur		21. Signature of Funeral Service L.Co.						ineral Hom		
ă	Depa Impo any I		トラター は、し	0-	1	2 Ridgely	Ave. A	Annapolis,	MD 21401		
1	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.						Approximate Interval Between	
6.	Physician		Immediate Cause (Final disease or condition	, 50	PSIS	, ISC	HOMIC	BOW	26	Onset and Death  24 HOURS	
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	,	1000	BOW		701100-0	
海	Lxammer	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	prequence of):	DI	SUMS	-		20 years	
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	220 10 (01 23 2 01	311004201100 017.						
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	ate be executed hysicien and the burial-transit	cai		d							
9	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit		IF FEMALE:								
Вох	eath certific ettending p I for use as I	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnanc	у		23d. Date of delivery  Month Day Year		
o.	the all	sic	1 Yes 2 No	4□Pregnant at tim 9□ Unknown	e of death 5	Other (specify) _					
۵.	that the de led by the e detached t		Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?	
Records,	uires that signed to	d by	ROWAL FAL	LURE				1 🗆 Ye	os 2-0 No 3 D P	robably 4 Unknown	
COL	w requir sbeen si should	iete	RPCURRENT	ASPIRA	TION F	Neun	aniA	24a. Was a	n 24b. Were a	utopsy findings available	
Re	The lav te has age 2	Completed		0///		3		autops perform	ned? death?	completion of cause of	
Vital	ysician: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?		/		26. Place of De	eath (Check only on			
of <	Physician: r this certifica ral director, I	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 - R/Outpatie	ant 3[] DOA			nce 6 Other (Sp.	ecify)	
n o	ding Ph h. After th tuneral		27. Manny of Death  1 atural 5 Pending	28a. Date of Injury (Month, Day Ye	ea <i>r)</i> 28b. Time Injury	Wo		28d. Describe ho	w injury occurred		
Sio	Attending r death. ector: After by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b	9 Place of Injury	. At home form s		Yes 2 No	28f Location (St	reet and Number or F	Rural Route Number.	
Division	after or Ai	Certification:	4 Homicide determined	building, etc. (S		ireer, ractory, office		City or Town	n, State)		
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the			nysician: To the best of n							
	To the Ho within 24 to the Fu completely	edicai	(Check only 2 Medical Examone)	miner: On the basis of ex and manner stated							
	To the withing To the complex	Σ	29b. Signature and title of certifier	111	Man	29c. Licen	se number		9d. Date signed (Mor		
<b>.</b>	F ≯ F 5	1			- 0 11 115 11 11 11			2/ / //	VANIBUALLO		
è	/\ .		home	- / 7	0000	1	7626		DUENTISE	10,200g	
•	10,00	V	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	a, Print)	1626	Luca N	Lipps wer	20071100	
	10/0	V	30. Name and address of person who ICHAEL  31. Date filed (Month, Day, Year)  NOV 2 1	1. ANKPER	1 8601	a, Print)	40 50 VS/1/6/1	may MI	LLEESVILL	PE 18,2007 eMDZ1108	

2007 39426

Bozman		4 5	or State	St	ate o	f Maryla	nd /	Depar	tment o	of Health of Death	and Men	itai Hyg		. No.			
		Doo	istrar Decedent's Name	o /First Midd	le Last)				- Inouto c			2	Date of Death		Year	3. Time of D	1
hysicia xami		า. เ	ANNIE	SMITH		MAN						1	Month November	23, 20	07	1340 h	S
. Adiiii	ici	4a	Facility Name (i				mber)			4b. City, Tow	n, or Location	of Death			County of Dea	th	
			Penninsula	Regional	Medic	al Center				Salisbu	,			1	comico	intholace (State	9.00
Funeral		5.	Social Security N	Number	6. Sex		7. Age	(In yrs. las	st birthday)	If Under 1	Year If Und		8. Date of Birth		Fore	ign	
Director		2	14-32-5	032	1 1	и 2 <b>X</b> F			74 Y	rs.	Days	10 101	5/31/1	933		country) Vir	ginia
			ual Residence o													10d. Inside	City Limits
any			a. State	10b. County			ļ	10c. City,	Town or Loc	ation						1 X Yes	2 No
nd show nce.	5		MD	Worce	este	<u>r</u>		Pocc	moke		- 40		110	a. Citize	en of What Co	ountry?	
faryla 28a-f 1 at o	Director	10	e. Street and Nu	ımber						10f. Zip C					JSA		
the A	اق	1	1510 Snc	w Hill	L La	ne			0 42	218		rigin? ( Spe	ecify Yes or No-			erican Indian,	Black,
n with ms 2, be n	Funeral	11	Never Marr	ind 2	Married	12. Was De Armed F	orces?		5.	If Yes, specify	Cuban, Mexica	an, Puerto F	Rican, etc.)	1	White, etc		
deatl or ite	ᇤ	1				1 Yes If Yes, Give Ye		X No	1	Yes 2	X No speci	fy:			Specify: W	hite	
s after	र्व	`├-	Widowed  15. Decedent's E			or Dates:		npleted)	16a Dece	dent's Usual O	ccupation (Giv	ve kind of w	ork done	16b. K	ind of Busines	ss/Industry	
hour "natu	ted	-	Elementary/Sec			College			durin	most of worki	ing life. DO NO	Ji use retiir	eu)		C 1		
36 hin 72 than than	월		12						Cleri	cal				1	nufact	uring	
d with	Completed	1	7. Father's Name	e (First, Midd	le, Last)								(First, Middle,		Surriame)		
21215-0036  Juld be filed within 72 hours after death with the Maryland Nannel Hygiene.  marked other than "natural", or items 23a or 28a-f show (event, the Medical Examiner must be notified at once.	å	: l	Walter	H. Sm	ith				100 14	Nin - Address	(Street and b	terre	Minner Rural Route Nur	nber, Ci	ty or Town, S	ate, Zip Code)	
5 2 2 5	<u>ا</u>		9a. Informant's N						19b. Ma	ning Address	n Lane	- Ona	ncock,	VA 2	23417		
MD dd 2 shorth and m 27 is aumatik	1		Donald I		(sc	n)		20b.	Place of Dis	sposition (Nam	e of cemetery,		Date	20c.	Location - City	or Town, Stat	е
ages 1 and 2 should nt of Health and Nt. If item 27 is not the traumatic	1	12	1 Burial 2	Cremat	ion 3	Removal	from S	tate	crematory o	r other place)			27/2007	7 52	lighur	v. MD	
Page nent c	1	1	4 Donation	5 Other	Specify:			_   Sa	lisbury	Cremato	Address of Fau	cility	21/200	-6-2	ricool A	comiati	
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 iniury or other traumat	:	2	1. Signature of F	Funeral Servi	ce Licen	see				Hollowa 102 Tir	y Fune	ral H	ome, Pr	Ci	ty, MD	21851	<u> </u>
1	_	4	23a. Part I. Enter	the disease	or come	lications that	t cause	d the death	n. Do not en	ter the mode o	of dying, such a	as cardiac c	or respiratory ar	rest, sh	ock, or heart	Applox	mate Interval n Onset and
rsicia: ledica		Ì	failure. List	only one cau	ise on ea	ach line. Pulmonal											Death
Examine			Immediate Cause or condition resu	e (Final disea Ilting in death	1)	Due to (or as	s a con:	sequence	of):								
		П	Sequentially list		b	Deep Ver											
	à	5 I i	if any, leading to cause. Enter Ur	immediate	ıse	Due to (or a	s a con	sequence	of):								
	7	EΙ	(Disease or Injur events resulting	ry that initiate	ed .	Due to (or a	s a con	sequence	of):								
0, the executed sician and	i la la				d				_								
be exec	1 2	a G	UNPEND	ED	15	AMENDE	erMi	E. <b>G</b> 874	. 12/27	/07 TT				12	3d. Date of de	livery	
Sox 68760, leath certificate be attending physical		ğΙ	IF FEMALE: 23b. Was decede	ent pregnant	in the		es, outo /e birth	ome of pre	gnancy 2	Fetal death	3 E	ctopic pregr	nancy	-	Month	Day	Year
68 certifi	Sc ds	֓֞֟֟֟֟֟֝֟֟֟֟֟֟֝	past 12 mor					at time of		Other (Spe				- 1			
Box 68760 e death certificate the attending phys	101	Physician/Me	1 Yes 2		Unknow	9 0	known						230 Did	Uobacc	o use contribu	ite to the caus	e of death?
O. B. it the de	дегаспед		Part II. Other si	gnificant co	nditions	contribution	ng to de	ath but no	t resulting in	the underlying	g cause given	in Part I.				Probably 4	
ords, P.O. w requires that the		힐											24a. W		24b W	ere autopsy fin	dings available
rds requi	ponid .	용											au	lopsy rformed	pri	or to completic ath?	n of cause of
e law te has	ge 2 s	Completed											1 ✔ Ye	s 2		/ Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  "In Director: After this certificate has been si			25. Was case re	eferred to me	edical						26.Place of D			Dest	idence 6	Other:	
<b>Vita</b> ysicia his ce	direct	o Be	examiner?	2 No		Hospital: 1	Inpa	atient 2	✓ ER/Out		DOA	1 110	sing Home 5		injury occurre		
of Ving Phy	ınera	⊢ŀ	27. Manner of D			28a. [	Date of Month, Da	Injury ay,Year)	28b. Tii	me of Injury	28c. Injury at		200, Descri	00 11011	,,		
On lendir eath.	the fu	흹	1 ✓ Natural  2 Accider		Pending Investiga					fasta			28f Locatio	n (Stree	et and Number	or Rural Rout	e Number, City
ViSI or Att firer de	in by	ertification:	3 Suicide	0	Could n	ot be 28e.		of Injury - A	t home, farr	n, street, factor	ry, office build	ing, etc.	or Tow	n, State	)		
Spital lours a	filled	Cer	4 Homici		determin				I- dee deet	occurred at the	he time date a	and place, a	and due to the o	ause(s)	and manner	as stated.	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	completely filled in by the funeral		29a. Certifier 1 (Check only one)	✓ Certifyi	ng Phys I Examir	ner:On the ba	asis of	examinatio	ieage, aeati in and/or inv	estigation, in r	my opinion, de	eath occurre	d at the time, d				(s)
To the	comp	Medical	29b. Signature			and man	ner stat	ed			9c. License nu			29	ed. Date signe	d (Month, Da)	/,Year)
		_	200, Signature	18	11	11 00	Λ			l	O.C.M.	Ε.		N	lovember :	24, 2007	
			30. Name(and	u/w	FROM W	no complete	cause	of death ()	tem 23a)								
ET 12				E. Southa			ant M	edical E	xaminer	111 Per	n Street, E	Baltimore	, MD 21201	l			
L' 10		ate					32. Reg	istrar's Sig	nature	boarde	,						
Re	gist			NOV S		2007	Bu	gue	D.	7			-	DOME			
DHMH 17 Re	1/20	001		MOA.		-			ORI	GINAL							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Month **Physician** 645PM 9-200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cherry Lane Nursing Center Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign New York 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth OCL. 2,1906 **Funeral** Months Days 1 ☐ M 2 🛱 F Hours Min. 579-01-7907 101 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Exeminar must be notified at 10d. Inside City Limits Maryland Prince George's Beltsville 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 10906 Fleetwood Drive United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a any injury or other freumatic event, the Medical Examinar must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: White Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1-4 Office Personnel Management Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John E. Dunn Elizabeth Harris 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Whitcraft, Sr. -son 10906 Fleetwood Drive Beltsville, Maryland 20705 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Fort Lincoln Cemetery 11/24/2007 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit Due to (or s a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ should be 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an this certificate has al director, page 2 autopsy 1 Yes 2. No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) 1 Tes Hospital: 2 2 🗔 🕫 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4K Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? ei or Attending P s efter death. ii Director: After t 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospitei within 24 hours e To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 1020 GREEN BELL 1 HUIS 31. Date filed (Month strar's Signature State 3 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day George A. Ballas Vovember 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death tospita Easton 1a166 If Under 1 Year | If Under 24 Hrs Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**√**M 2□ F 214-30-8164 75 Director Mar. 8, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at MDCaroline Federalsburg 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Academy Avenue 21632 the Medical Examiner must United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Bus. Owner & Operator permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important; if item 27 is marked other the any linjury or other traumatic event, the ans linjury or other traumatic event, the anset is a proper traumatic event, the anset is a proper traumatic event. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Anthony George Ballas Laura Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Ballas/Spouse 216 Academy Avenue, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery Denton, Maryland 11/30/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Milleret 216 N. Main St., Federalsburg, MD 21632 Uskur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Bleeding 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifie

30. Name and address of person with

DHMH 17 Rev 1/2001

Seorge

completed cause of death (Item 23a) (Type, Print)

MEMORIAL

29c. License number

29d, Date signed (Month, Dav. Year)

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day BERTHA ANNA BEITZEL 12 03 /Medical 2007 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F 79 Director 214-34-1279 1928 Aug. 8, Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location show a or 28a-f show t be notified at 10d. Inside City Limits Director 1XYes 2 No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 25 N. Pennsylvania Ave. 21536 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any Injury or other traumatic event, the ones. Meat Wrapper Meat Packing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Beitzel Arminta Maust 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvin R. Beitzel/Brother 10089 Mason-Dixon Hwy., Salisbury, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Old Cherry Glade Cem. Dec. 7, 2007 Accident, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. Cermas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypertensive cardiovascular hrt disease or condition resulting in death) P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse quence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed? Yes 22 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 KER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day s after death. Il Director: A od in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)
Dec 12 2007 Do9157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dpty med ex 124 W 3rd St Cumberland Md 21502 Paul Snow, M 31. Date filed (Month, Day, Year) M.D. 32. Registrar's Signature State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State of Maryland / Dep	ertificate of Death	Mental Hyg	Reg. No. 2007	39430		
ı	Physici		Decedent's Name (First, Middle, Last)     James Allan Craig		2. Date of Dea Month	Dav Year	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 9707 Winery Court	4b. City, Town, or Location of Deat Gaithersburg		21, 2007 10:15A M 4c. County of Death Montgomery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		(Month, Day	y, Year) 9. Bir	thplace (State or Foreign ountry)		
ı	Director		Usual Residence of Decedent		Jan. 6,	194/ Was	hington, DC		
	Marylar f show lied at	tor	10a. State   10b. County   10c. City, Town or L   MD   Montgomery   9707 Wine	ocation ery Court Gaithers	sburg, MI	)	10d. Inside City Limits 1 XYes 2 No		
215-0036	3a or 28a st be noti	al Director	10e. Street and Number 9707 Winery Court	10f. Zip Code 20879		10g. Citizen of What Co United St	ountry?		
	be filed within 72 hours after death with the Maryland that Hyglene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Mas Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 ☐ Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)				
-C.	iin 72 h n "natu A-dical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation o kind of work done during most of wor DO NOT use retired)	rking	16b. Kind of Business	/Industry		
7	filed within 72 Hygiene. other than "nai ent, the Medica			ntral Office Tech		Telephone	e		
Ž.	uld be fi fental F rked ot tic ever	To Be	James Angus Craig	Maiden Surname) abeth Ward	,				
Mary	12 should be h and Menta 7 Is marked raumatic ev		19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Ru	ural Route Numbe	r, City or Town, State,			
e, l	t. Pages 1 and rtment of Health rtant: If item 27 njury or other to		20a. Method of Disposition 20b. Place of Disp	Winery Court Ga:  osition (Name of matory or other place)	ithersbur Date	rg, MD 208 20c. Location - City or			
baitimor			4 Donation 5 Other (Specify) Nation1	Crematory 11/2	2/2007	Falls Chu	ırch, VA		
a	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Jos 130 Wisconsin Ave	seph Gawl	Ler's Sons,	Inc. OC 20016		
	1		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardian	c or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Pneumonia  Due to (or as a consequence of):			Onset and Death			
	Examiner		Multiple Salare	sis					
4	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
Ď,	oe exec cian and curial-tra	e Exa	resulting in death) Last C. Due to (or as a consequence of):			· · · · · · · · · · · · · · · · · · ·			
00/00	rificate be executed g physician and as the burial-transit	edical	d						
.O. DOX	death cer ne attendir ed for use	ıysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year				
L'A'	iires that signed by	by Phys	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did to	bacco use contribute to	o the cause of death?		
scords,	law requas been 2 should	Completed			24a. Was a	n 24b. Were a	utopsy findings available		
ומוו ח	vsician: The lavius certificate has director, page 2	Com			autops perfori 1⊟ Yes	med?   death?	completion of cause of 2 □ No		
<b>&gt;</b>	ysiciar s certif director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🏋 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othori	ath (Check only on	e) ence 6 □Other (Spe	aif d		
5	ing Pr After th uneral	on: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury	f 28c. Injury at Work?		ow injury occurred	city)_		
	or Attendifter death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, stream building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (St City or Town	treet and Number or Ri n, State)	ural Route Number,		
	To the Hospital within 24 hours a To the Funeral t completely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	s stated. e to the cause(s)		
	To th Comp	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)		
i	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	D006415		11/21/200	07		
			Genevieve Wroblewski MD 1355 Pic	ccard Drive Rocky	ville. MI	20850			
	Stat Registra	e ir	21 Date filed (Month Day Vear) 32 Majetrar's Signature	rasti)					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death Examiner NOSHING 5. Social Security Number 8. Date of Birth (Month, Day, Year, 7. Age (In vrs. last birthday) **Funeral** ce (State or Foreign 1XM 2□F Months Days Hours Country Director 213-42-1476 65 May 22,1942 Marvland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits Director Washington 1 ☑Yes 2 ☐ No Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Lerov Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Deced .... Armed Forces? 1 □ Yes 2 No Black, White, etc. 1 Yes 2 X if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 Ó Painting Contractor Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Carbaugh Omar Helen Louise Knox 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol J. Rockwell 134 Almost Heaven Road, Falling Waters, W.Va. Sister 25419 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 12-02-07 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Marvland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. R. hoel Brady 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of see on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as consta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was a autops perforr 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Inpatient Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician the for use the detached þ signed I page 2 should certificate has Physician: funeral director. this After t or Attending

28a-f show notified at

must

Examiner

the

contant: If item 2 Injury or other

Important: I any Injury o

other

or items

'natural',

death with ō 8 23a

filed within 72 hours after Hygiene.

1 and 2 should be Health and Mental

Pages 1

Maryland 21215-0036

Baltimore,

Medical Certification: To

filled in by

13H-5

after death Director:

24 hours a Hospital

To the

State Registrar 31. Date filed (Month, Day, 30

4 Homicide

29b. Signature and title of cert

29a. Certifier (Check only one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		4	For State	State of Maryland		artment of Hetificate of L			71111	7 394	32
	_		Registrar  1. Decedent's Name (First, Middle, Last,	}	001	incate of E	704111	2. Date of Death	J. N6 U U	3. Time of E	
	Physicia			ght Cavana	anah			Month	•	'ear	ма
	/Medic		4a. Facility Name (If not institution, give		lugii	4b. City, Town, or	Location of Death	Novembe	4c. County of	007 4:4 Death	2
	Examin	er	116 Covered Bride			Fruit			Wicon		
	Formul				t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or	Foreign
	Funeral Director		5. Social Security Number 258–58–7907 6. Se.	□M 2⊠F 72	Yrs.	Months Days	Hours Min.	2/26/193		Georgia	
	10		Usual Residence of Decedent							404 1 - 14 - 05	. I familia
	rylan		10a. State 10b. County		Town or Lo					10d. Inside City 1 ☑ Yes	
	Ba-f s	cto	Maryland Wicomic	0 F	ruitl						
	or 28	Director	10e. Street and Number			10f. Zip Code	_	10	g. Citizen of Wh	at Country?	
	ath w		116 Covered Bri		140.1	2182		and Was as No	USA 14 Page	American Indian,	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)		White, etc.	
36	ours after death with the Marylan ral', or Items 23a or 28a-f show Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	white	
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	ed t	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		6b. Kind of Busi		
15	In 72	plet	(Specify only highest grad		(Give life.	kind of work done of DO NOT use retired	luring most of worki )	ng			
212	filed withln Hygiene. ethar than "	Completed	Elementary/Secondary (0-12)	2	home	maker			domesti	С	
Þ	be filed within 72 ho ital Hygiene. id othar than "natui evant, its Mad sal	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Sumame,	)	
<u>la</u>	Venta Venta rikad	ToE	Wendell Byron Wi	ght				Harris			
Maryland	s 1 and 2 should be filed within f Heelth and Mental Hygiene. Item 27 is markad othar than " othar traumatic evant, I'te Mer		19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number,	City or Town, S	tate, Zip Code)	
	2 = 2 .		Patrick H. Cavana					1			
ore	ges 1 ar t of Hee if item 3 or othar		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I	Removal from State	ce of Dispo netery, crei	sition (Name of matory or other plac	θ)		uc. Location - C	ity or Town, State	
Ē	ment tant: jury		* 4 □ Donation 5 □ Other (Specify	Sali		7 Cremator		Company of the same of the sam	Salisbu		
Baltimore,	permit. Pages Department of It important: If ite any injury or of		21. Signature of Funeral Service ice	enes CFSD	2 i	Name and Address Olioway 1 Olionow 1	Funeral H Hill Rd.,	ome Profe Salisbu	essiona ry, MD	l Associat 21804	ion
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not en	er the mode of dyin-	g, such as cardiac	or respiratory arre	st,	Approximate Interval Bety	veen
	Physician		Immediate Cause (Final disease or condition	Lun	a Cau	ur				Onset and D	eath
	/Medical		resulting in death)	Due to (or as a conseque	ince of):						
	Examiner		Sequentially list conditions	b							
	י פּ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):			_			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	E		500 10 (0) 25 25 55 55 45						1	
87	physis the	dical		d							
9 X	leath certifica attending ph I for use as th	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnan					23d. Date	of delivery	
Box	ires that the death cer signed by the attendin d be detached for use	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			Mont	th Day Y	'ear
P.O.	the d y the	lysi	1 Yes 2 No	9□ Unknown							
	that ned b	y Pt	Part II. Other significant conditions co	ontributing to death but not result	ting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contrib	oute to the cause of d	eath?
rds	quires n sign	q pa						1 □ Ye	s 2⊡No 3	3 ☐ Probably 4 ☐U	nknown
of Vital Records,	w requir s been si should	lete						24a. Was an	24b. W	ere autopsy findings a for to completion of ca	available
Re	The la	E						perform	ned? / de	eath?	
ta	an: tiffica tor, p	a)	25. Was case referred to medical				26. Place of Deat	h Check only one			
>	Physician: this certific ral director,	To B	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	ome 5 Reside	nce 6 Other	r (Specify)	
0	ig Ph ter th neral	L:U	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurre	d	
<u>Ö</u>	Attanding r death.  ctor: After by the funer	atic	2 ☐ Accident investigation			M 1 🗆	Yes 2 □ No				
Division	r Attu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (Str City or Town	eet and Numbe. , State)	r or Rural Route Num	ber,
	To the Hospital or Attanding Physician: The law within 24 hours effer death. To the Funaral Director: Affer this certificate has completely filled in by the funeral director, page 2	Cel						a a d dua 4 - 45 -		anne an atatad	
	Hosp 24 hou Funa tely fi	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my know niner: On the basis of examination and manner stated.	nedge, dea on and/or in	th occurred at the tire of the	ne, date and place, pinion, death occur	red at the time, da	ite and place, a	nd due to the cause(s	)
	o the o the ornple	Mec	29b. Signature and title of certifier	arra mariner distress		29c. Licens	e number	29	d. Date signed	(Month, Day, Year)	
	F≥Fö		No him			04	7094		11/19	7107	
	10/		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)		-			
	04		vel NATESM	1415	C- DIG	1 Short	592151	sury	MB 2	.1804	
	St	ate	31. Date filed (Month, Day, Year)	32. Ragistrar's Signatu	ı.e	/					
	Regist	rar	NOV 262	007 Blown	d. Ja	porte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year DWIGHT EASLEY CAMPBELL 67 /Medical 22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO COASTAL HOSPICE AT 7 JALIS BURY LAKE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 04/12/1924 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 M 2 □ F 242-22-4519 83 North Carolina Director Usual Residence of Decedent 10a State 10b County Worcester 10c. City, Town or Location Pocomoke City 10d. Inside City Limits Show ral", or items 23a or 28a-f shov Examiner must be notified at Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Market Street 21851 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ₩ Widowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Management Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest E. Campbell Onie Alby 19a. Informant's Name/Relationship (Type. Print)
Deborah C. Shay/ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 2146 Tulls Corner Road, Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem Methodist Cem. 11/24/2007 Pocomoke City, MD 21 Signature of Fileral Service Licensee 22. Name and Address of FacilityHolloway Funeral Home, P.A. Much elin 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINO UNA MALIGNANT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dunito for as a consequence of The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ίοr in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 1 ☐ Yes the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2. 29b. Signature and tipe of certifier, 29d. Date signed (Month, Day, Year)

D OF LL

State Registrar

2007

C. HULAM 31. Date filed (Month, Day, Year)

WARG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



P.O BOX 1733 SALISGURY UD 21802

State Registrar

31. Date filed (Month, Day, Year) NOV 23 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



220

COVENSKY, FFLEN

		For	State of Maryla	-			Mental Hy		~ 00100
		1 - State Registrar		Ce	rtificate of	Death		Reg. No.200	7 0 3 1 0 0
Physi	cian	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	Day Yea	3. Time of Death
/Med				ae C	nandler	1	Novemb	er 20 200	
Exam	iner	4a. Facility Name (If not institution,			_	r Location of Deatl	1		
Funera	1	Frederick Memo: 5. Social Security Number	3. Sex 7. Age (In yi	rs. last birthday,	Freder  If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Freder:	Birthplace (State or Foreign
Directo	T I	216-22-8590	<sup>1□ M 2</sup> <del>x</del> F 96	Yrs.	Months Days	Hours Min.	Mar.	6,1911	MD Country)
pu »		Usual Residence of Decedent  10a, State 10b, County	10c.	City, Town or L	ocation				10d. Inside City Limits
Aaryla f shored at	٥		derick	Frede	rick				1 □Yes 2 No
r 28a- notifi	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
th with 23a ol ist be	a D	7407 Willow	Rd.		217	703		USA	
r deat ems :	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	- 14. Race - Al Black, W	merican Indian, hite, etc.
s afte	by Ft	1 Never Married 2 Marrie  3X Widowed 4 Divorced	d 1 Tyes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: T	Thite
tural sal Ex		15. Decedent's	Education	16a. Dece	edent's Usual Occup	pation		16b. Kind of Busine	
hin 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)		kind of work done DO NOT use retired	during most of word d)	rking		
d wit ygien ygien that the	Completed			t	eacher	40.44.0.1.1.	(F) A 18 A		schools
be fill Hall Hall Hall Hall Hall Hall Hall H	æ	17. Father's Name (First, Middle, L Jacob Ruc					ne (First, Middle, dith Bi	Maiden Surname)	
hould Mer	은	19a. Informant's Name/Relationshi		19b. Mail	ing Address (Street			er, City or Town, State	a, Zip Code)
IVICA nd 2 s lith an 127 is i			lece)	1	Broad S				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20t	o. Place of Disp	osition (Name of ematory or other place	ce)	Date	20c. Location - City	or Town, State
Page ment c		1 XBurial 2 ☐ Cremation	eatry					Middleto	
ermit. eparti nporta	ouce.	21. Signature of Funeral Service L	icentee 1-658	2	Donald Addre	S of Facility on	pson Fy	neral Ho etown, M	me 1760
	OI _	23a,Pad1. Enter the disease, or o	complications that caused the de	aath Do not er	31 E. Ma	aln St.	, M1dd1	etown, M	Approximate
		shock, or heart failure. List of	complications that caused the de only one cause on each line.					11111	Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death)	a. Due to (or as a cons						2 DAYS
Examine	r	0 10 10 10 10 10 10 10 10 10 10 10 10 10	URINAM	ey 7	RACT	INFEC	TION		2 DAYS
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):		•			
cate be executed ohysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
ate be ex hysician a	鱼田		200 10 (01 40 4 001.0	70quo1100 01/1					
ficate g phys	edical		<b>0</b>						
h cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre 1□Live birth 2□F		□Ectopic pregnanc	v		23d. Date of	
e deat he atte ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of		Other (specify)	,		Month	Day Year
hat the d by t letach	Phy	9 ☐ Unknown  Part II. Other significant condition	as contributing to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	e to the cause of death?
requires the seen signed to a	by		21 - T				1 🗆 '	Yes 2 No 3□	Probably 4 Unknown
w requ	Completed	DEMENTIA,	6600	7			24a. Was	an 24b. Were	autopsy findings available
The large has	duc	- WENTED THE	years.				autoj perfo 1□ Yes	psy prior prmed? death 2☑No 1□N	
lan: 1 lan: 1 rtificat	Be Co	25. Was case referred to medical				26. Place of De	ath (Check only o		20 20110
hysici nis ce	ToB	examiner? 1 Yes 2 40	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing F	Home 5 ☐ Resi	dence 6 Other (5	Specify)
Ing Ph		27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	Wor		28d. Describe	how injury occurred	
ttend death.	cati	2 ☐ Accident investigation in	ot be 289 Place of injury - Al	t home farm, s		Yes 2 No	28f Location (	Street and Number or	Rural Route Number,
after after d in by	Certification:	4 ☐ Homicide determin	building, etc. (Spe	ecify)	,		City or To	wn, State)	
ospita hours ineral	alC	29a. Certifier 1 Certifying	Physician: To the best of my lexaminer: On the basis of exam	knowledge, dea	th occurred at the ti	ime, date and plac	e, and due to the	cause(s) and manne	r as stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	one)	and manner stated.	miation and/or i			aneo at the time,		
with To 1	Σ	29b. Signature and title of certifier	son he		29c. Licens	1921		29d. Date signed (M	onin, Day, rear)
		Donek		tom Oge /Tre-	Print)	-/50		1/	
S		30. Name and address of person v	ino completed cause of death (I	Homas	COHNSO	J DRIVE	FRE	BERIOE	21702

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) NOV 2 6 2007

Norma Almeraya Soria Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08998 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 21, 2007 0715 hrs Norma Almeraya de Soria Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Springs 11499 Columbia Pike Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Mexico Country) 218-79-0047 Director M 2 F 35 1972 Yrs Sept. 7, Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location RIV 10b. County 10a. State 1 Yes 2 X No realli ain included 128a-f. show fraunzi is marked algebra. Iraunzi is cevent, the Medical Examiner must be notified at once. Spring 10f. Zip Code Maryland Montgomery Silver Director 10g. Citizen of What Country 10e. Street and Number 11604 Stewart Lane, #402 20904 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 2 X Married Never Married 2 X No Yes Mexican SpecifyWhite Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or
injury or other traumatic event, the Medical Examiner m 1 X Yes 2 No specify: Divorced If Yes. Give Year 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amparo Lara Be Pablo Almeraya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Silver Spring. MD 2 20c. Location - City or Town, State MD 20904 Roberto Soria Martinez/Husband 11604 Stewart Lane 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 29, Nov. PanteonciviI/San 1 X Burial 2 Cremation 3 X Removal from State 2007 Mexico City, Mexico 4 Donation 5 Other Specify: Tolentino Nicolas 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring MD 20901 23a. Part I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and Death 'Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED by the attending physician ached for use as the burial 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 No 3 Probably 4 V Unknown signed be deta þ Records, P. Completed 24b. Were autopsy findings available 24a. Was an peen autopsy prior to completion of cause of death? performed? has 2 No ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) NoV 21, 2007 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Subject pedestrian involved in motor vehicle Certification: 0659 hrs 1 Yes 2 ✔ No Natura Pending accident 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 11499 Columbia Pike, Silver Springs, Md. Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME November 22, 2007 O.C.M.E. 30. Name and address of person who completed have of death/(Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. egistrar's Signatur 31. Date filed (Month, Day, 32.1 6 State 2007

DHMH 17 Rev 1/2001 OCME 2006

Registra

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		St	ate of Ma	aryiana /		artment of F <i>rtificate of</i>				giene Reg. No.	007	0.01.00
	Physici	an	1. Decedent's Name	(First, Middle,	Last)	112		-				2. Date of Dea	ath _	U J /	3 Time of Death O
	/Medic	al	Doris Jo						41. 0'5. T			Novembe		2007	2:00 рм
	Examin	er	4a. Facility Name (If		_		a l		4b. City, Town, o	or Location	or Death			ounty of Death utgomer	
	Funeral		5. Social Security Nu		6. Sex	7. Age	e (In yrs. last	birthday)	If Under 1 Year Months Days	If Unde	r 24 Hrs.	8. Date of Birt (Month, Day April 2	th v. Year)	9. Birth	place (State or Foreign intry) Virginia
ĸ.	Director		<b>235-42-3</b> 4 Usual Residence of I		1 □ M	2 <b>X</b> JF / /	D	Yrs.	monaid Baye	1104.0		April 2	26,192	29 West	Virginia
	yland ow at		10a. State	10b. County			10c. City, To								10d. Inside City Limits
	e Man a-f sh tiffed	ctor	MD	Montgo	mery		Silve	r Sp	ring						1 □Yes 2¥ No
	vith th	Director	10e. Street and Num						10f. Zip Code					n of What Cou	intry?
	eath v ns 23a must	Funeral	1009 CL	iftonbr		ane. Vas Decedent B	ever in U.S.	13.	20904 Was Decedent of H	Hispanic C	rigin? (Spe	ecify Yes or No	USA 14	. Race - Ameri	ican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Marrie		d 1	rmed Forces? □Yes 2 <b>1</b> Yes, Give ear or Dates:			Was Decedent of H If Yes, specify Cub 1 □ Yes 2 ☑ No			Rican, etc.)		Black, White pecify: Whi	
2	72 ho 'natur dical i	eted	(Special	15. Decedent's fy only highest	Education grade con	n npleted)	1	6a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during mo	st of worki	ing	16b. Kind	of Business/Ir	ndustry
121	within ene. than "	Completed	Elementary/Secon	ndary (0-12)	С	ollege (1-4or 5	+)	Ar.	DO NOT use retire <b>tist</b>	d)			Ara	t	
<u>б</u>	Hygie other ent, th	Be Co	17. Father's Name (	First, Middle, La	as <i>t)</i>					18. Moti	ner's Name	e (First, Middle,	Maiden Su	ırname)	
/lan	wild be Menta arked	To B	Dorus C.	lark Ru	ssell	2						lae Rusi			
Maryland 21215-0036	id 2 sho Ith and I 27 Is me traume		19a. Informant's Nat Gary S.			rint) Son	7	19b. Maili 1 <b>00</b> S	ng Address ( <i>Str</i> eet <b>tratkord</b>	and Num.	ber or Run	race, S	er, City or T <b>ilver</b>	own, State, Zi	ip Code) 3, MD 20905
ē,	s 1 and Heal		20a. Method of Dispo	osition			20b. Place	e of Dispo	osition (Name of matory or other pla	ice)		Date	20c. Loca	tion - City or T	own, State
Ē	Page Trent c		1 Burial 2 □ 4 Donation			al from State			emorial 1		11/26	5/2007	Olney.	, MD	
Baltimore,	permit. Departimontal		21. Signature of Fur	neral Service Li	censee	a cerr	t	11	2. Name and Addre	ess of Faci Hamp&	hite	res-Rina Avenue	aldi.	Funeral ver Sp	Home Ling, MD20904
	ē.		23a. Part1. Enter the shock, or hear	e disease, or c t failure. List o	omplicatio nly one ca	ns that caused use on each lin	the death. D	o not ent	er the mode of dyi	ng, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
X.	Physician /Medical		Immediate Cause (F disease or condition resulting in death)		a				·y H	YPE	fersic	217			Y CC-5
3	Examiner		, , ,	- 1		Due to (or as	a consequen	ce of):							
	100	ner	Sequentially list con if any, leading to imreause. Enter Under Cause (Disease or in the control of the control	ditions, mediate	b	Due to (or as	a consequen	ce of):							
	ecuted and transi	Examiner	Cause (Disease or in that initiated events resulting in death) La	njury	c	2									
68760,	ificate be executed j physician and as the burial-transit					Due to (or as	a consequen	ce or):							
687	ificate g phys	edical			d										
Vital Records, P.O. Box	attending for use	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	pregnant nonths? No	1 4	yes, outcome □Live birth □Pregnant at □Unknown	2 ☐ Fetal de	ath 3[	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y			230	d. Date of deliving Month	very Day Year
٣.	w requires that the d been signed by the should be detached		Part II. Other signific	cant condition	s contribu	ting to death bu	ut not resultin	g in the u	nderlying cause giv	ven in Parl	t I.	23e. Did to	obacco use	contribute to	the cause of death?
rds	quires en sign uld be	ed by										1 🗆 🗅	Yes	No 3□ Pro	obably 4  □Unknown
eco	law re as bee 2 sho	Completed										24a. Was		24b. Were aut	topsy findings available ompletion of cause of
<u>~</u>	sician: The law certificate has b irector, page 2 s	Com											rmed?	death?	2 □ No
<u> </u>	certifi	å	25. Was case referre		Hospit	al:		(2 ) (1	ot 3 DOA Oth	oor:		h <i>(Check only o</i>			
ō	g Physer this eral di	7: To	1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 27. Manner of Death			la. Date of Inju		b. Time o	f 28c. Inju	ry at		me 5 Residence 128d. Describe I			ify)
0	ath. or: Afte	atior	1 Natural 2   Accident	5 ☐ Pending investiga		(Month, Day	(Year)	Injury	M 1 🗆	rk? ]Yes 2[	□No				
Division or	To the Hospital or Attending Physician: within 42 hours differ death. To the Furneral Director: After this certifica completely filled in by the funeral director, r	Certification:	3□ Suicide 4□ Homicide	6 ☐ Could no determin		le. Place of inju building, etc	iry - At home c. (Specify)	, farm, sti	eet, factory, office			28f. Location (8 City or Tov		Number or Ru	ral Route Number,
	he Hospil n 24 hour ne Funer	Medical (	29a. Certifier (Check only one)	Certifying	xaminer:	n: To the best of On the basis of and manner sta	examination	dge, deat and/or ir	h occurred at the ti vestigation, in my	ime, date opinion, d	and place, eath occur	and due to the red at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	Vithi To f	Ž	29b. Signature and t	title of certifier	1	01			29c. Licens					signed (Month	
•	6		- (	MillEV	3		1516165		D.L.	1000	5569	.4	Nov	enbe-	21,2007
	2150			WK	-	THUR	_ L	1000		08	017	iey, M	D 2	0832	
	Sta Registr		31. Date filed (Mont)	h, Day, Year)	2007	32 Aegistra	ar's Signature	An	ale						

Box 68760. P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

Physician /Medical Examiner the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certification: To 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contine D40324 NOVEMBER 23,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURROTTS ROAD, CLINTON, MARYLAND 20735 TERRY JOINRIE, MD Registrar's Signature 31. Date filed (Month, Day, Year) 32. NOV 26 Registrar **ORIGINAL** 

and

nding physician

Division or Vital Records, P.O. Box 68760,

for use as the burial-tran

signe be

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ဥ

**Funeral** 

Director

n		
n al er		
et.		
-	ner	
	Ē	
	EX	
	ल	
	ğ	
	ž	ľ
	an	
	sic	
	اخ	
	Ž	
	5 7	
	ete	
	밑	
	S C	
	Be	
	ဂ္	
	ë	
	[엹]	
	ificati	
	erti	
	I Certi	
	<u>:</u>	
	Jec	
	~	

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1XXInpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier (E) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d65953 November 21, 2007 of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Adaku Onjukogu, MD

State Registrar 31. Date filed (Month)

Day, Year,

NOV

DHMH 17 Rev 1/2001

To the Hospital or Attentions within 24 hours after death.

To the Funeral Director: Af

House St. Roselle **ORIGINAL** 

32. Redistrar's Signature

DHMH 17 Rev 1/2001

/Medical Examiner **Funeral** Director death with the Maryland r 28a-f shov notified at altimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be it Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 10 = 10 Department o Important: If any injury or

Physician /Medical Examiner

attending physician and for use as the burial-tran ed by the a signed by director, this After

death certificate be executed To the Hospital or Attending Physician: the funeral after death. 24 hours a within 2. To the I

Division or Vital Records, P.O. Box 68760,

Vaden Dudlev November 2007 8:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8104 Water Street Road Walkersville Frederick If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 11XM 2□ F 83 31, 224-26-6860 Oct. 1924 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8104 Water Street Road 21793 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: ģ 3 ₩ Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Routeman Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William W. Dudley Sallie M. Sheltman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21793 19a. Informant's Name/Relationship (Type. Print) Patricia Bargas / Daughter 8104 Water Street Road Walkersville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Stauffer Crematory 4 Donation 5 Dother (Specify) 24, 2007 Frederick, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the dise set or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 40 disease or condition resulting in death) tachure Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dysphag 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1∑ Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natura! 1 ∏ Yes 2 ∏ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058726 - MO 11-21-07 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) Warren 3000 -D Ventrie Ct Myersville MD 20874 vette MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2007 7 Registrar

シャ

			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of F rtificate of		entai Hyg R	eg. No. 20	07	3944	3
	Physici	an	1. Decedent's Name (First, Middle, La	st)				Date of Deat Month	Day	Year	3. Time of Death	
	/Medic	_	George Paul Elia			41. O'T. T.	- Landing (Dark	11 0	21 0		0500	1
9	Examin	er	4a. Facility Name (If not institution, giv		Apall -	4b. City, Town, o	r Location of Death		4c. County o	Death COM	ièo	
200	Funeral		Teninsura Klajowa L  5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year		8. Date of Birth	1	9. Birthr	place (State or Foreig	חו
	Director			<b>№</b> М 2□ F	67 Yrs.	Months Days	Hours Min.	(Month, Day, April 3		Coui	nsylvania	
	/land ow		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limit	s
	Mary a-f sh ffed	tor	DE Suss	ex	Laurel						1 ☐ Yes 2 🛛 No	)
	or 28%	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	nat Cour	ntry?	
	ath w	ral	16533 Adams Road			1995			U.S.			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	io l	Was Decedent of H If Yes, specify Cub  1 ☐ Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecity Yes or No- Rican, etc.)		, White,	can Indian, etc. nite	
15-0	n 72 ho "natur edical E	Completed by	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	ng	16b. Kind of Bus	iness/In	dustry	
712	withi jene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5	+)	Owner	-,	E	Truckin	g Co	mpany	
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last	)			18. Mother's Name	(First, Middle, I	Maiden Surname	<del>!</del> )		
/lai	Menta Menta arked atic e	ToE	George Paul Elia	s, Sr.			Laura Fu	ırry				
lar	2 shc and is ma		19a. Informant's Name/Relationship (		1	-	and Number or Rura			itate, Zip	o Code)	
e,	1 and Health em 27 ther to		Betty Ann Elias 20a. Method of Disposition	(Wife)	20b. Place of Dispo	33 Adams		arel, DE	20c. Location - 0	iby or T	own State	
Baltimore, Maryland 21215-0036	: Pages tment of I tant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	fy)	Springhi Memory G	matorý or other pla 11 ardens	Nov. 26		Hebron,	•		
Bal	permil Depar Impor any ir		21. Signature of Funeral Service Lice	( )	, S1	2. Name and Addre hort Fune 3 E. Grov	eral Home re St. De	lmar, D	E 19940	)		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not entire.	ter the mode of dyi	ng, such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Mul	Horgan	fals:	2			81	1 clary	
	/Medical Examiner		resulting in death)	Due to (or as	a consequerce of):						0	
9	- gas	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	a consequence of):					-	1 dany	_
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								0	
o,	tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):							
68760,	ate be hysici the bu	edical		_d							<del></del>	
.O. Box 6	eath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date Mon		rery Day Year	
۳.	that the poly detact	y Ph	Part II. Other significant conditions	contributing to death be	ut not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tol	bacco use contri	bute to t	the cause of death?	
rds	quires	ed by	rectal	cance				1 □ Y	es 2 No	3□ Pro	babiy 4 □Unknow	'n
Vital Records, P.	To the Hospital or Attending Physician: The law requires that the dwinth and the Lathours affector. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed						24a. Was a autops perfori	męd? pi	rior to co eath?	opsy findings availab ompletion of cause of	le
ita	stan: artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Death				20.10	_
	hysic this co	2	1 Yes 2 No	Hospital: Inpatie		N OLI DOA	ner: 4 Nursing Hor	me 5 🗆 Reside	ence 6 □Othe	r (Speci	fy)	
n C	ing F		27. Manner of Death  1 → Natural 5 □ Pending	28a. Date of Inju (Month, Da)		Wo		28d. Describe ho	ow injury occurre	d		
Division or	Attending Physician: or death. ector: After this certification in the funeral director, is	ficat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e Place of init	ury - At home, farm, sti		]Yes 2 □ No	28f. Location /Si	treet and Numbe	- er or Rur	al Route Number,	_
<u>≥</u>	al or A	Certification:	4 ☐ Homicide determined	building, etc	c."(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Towi		, 0, , 10,		
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		nysician: To the best of miner: On the basis of and manner sta	examination and/or in							
	To th within To the	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed	(Month,	, Day, Year)	_
) .	(~1		Un Chi	~ ~	(1)	D56	.093		11:	11	20007	
	122M		30. Name and address of person who					1				
			Un Chin 100 E.	Carroll 57	1. SAlisbu	ry, Md.	21801					
	Sta Registr		31. Date filed (Month, Day, Year)	2007	ar's Signature	barle						

MONTGOMERY 9. Birthplace (State or Foreign Bolt via 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14 Race - American Indian Black, White, etc. White Specify: 16b. Kind of Business/Industry Own Home 20c. Location - City or Town, State Silver Spring, Md Approximate Interval Between Onset and Death DAYS YEARS 23d. Date of delivery Dav 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 11/10/2007 20732 OLNEY, MD

2007

15:25 PM

State Registrar

Medical

31. Date filed (Month, Day, Year)

Deborah

29b. Signature and title of certifier

29a. Certifier

(Check only one)

NOV 2 6 2007

Stew

18101 egistrar's Signature

PRINCE

and manner stated.

D,O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

PHILIP DRIVE

H 0065661

DHMH 17 Rev 1/2001

State

Registrar

NOV

6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month :30 PM **Physician** Langston D. Funn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. 1 M 2 □ F Director 66 Nov 6, 1941 215-38-6457 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State at 1 ☐ Yes 2 X No 28a-f st notified Director Largo MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or U.S.A. 20774 r than "natural", or items 23a the Medical Examiner must t 10633 Campus Way South Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. No 7/7/66 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 5/4/68 1 ☐ Yes 2 🕅 No Specify: Black 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marketing Salesman 7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Elizabeth Brown ٩ Horace G. Funn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10633 Campus Way South Largo, MD 20774 LaMarr Funn /Daughter item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Department of Important: If it any Injury or conce. 11/28/07 Cheltenham, MD 4 Donation 5 Dother (Specify) Cheltenham Veterans' Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Glady Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 💢 No 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No l Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral 6 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier

dRW 4+1

State Registrar 31. Date filed (Month, Day

TSCRHANE 303 V, Year) 32. Registrate Signature NOV 2 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



CHEVERLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dailey Esther Fulk November 19. 1:45 P M 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2700 Hidden Hill Court Huntingtown Calvert 8. Date of Birth (Month, Day, Year) Aug. 15, 1930 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 77 1 □ M 2 X F West Virginia 234-44-6315 Director Usual Residence of Decedent r 28a-f show notified at 10c, City, Town or Location 10a. State 10b County 10d. Inside City Limits 1 ☐ Yes 2X No MD Director Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? וווו אith be filed within 72 hours after death with t n and Mental Hygiene. Is marked other than "natural" בי ויחים יחים or S "natural", or items 23a dical Examiner must b 20639 2700 Hidden Hill Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify White þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the School Teacher Public Schools 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Pages 1 and 2 should <u>William Taylor Dailey</u> Esther May Hite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a
Department of Health ar
Important: If item 27 Is
any injury or other trau Bradley Fulk (son) 3548 Cassell Blvd. Prince Frederick. MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 26 Rosedale Cemetery Martinsburg, WV 2007 21. Signatur of Juneral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL MINUTE /Medical Due to (or as a consequence of) Examiner JRDIOVASCULAR DISFAF ATHEROSCLEROTIC Cause (Disease or injury that initialed ause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as attending properties as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 2 🗓 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 2 **JA**K 2 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A
oletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. the within To the

dew 10

State

29b. Signature and title of certifier

0

31. Date filed (Month, Day,

NOV

30. Name at

address of person who completed cause of death (Item 23a) (Type, Print)

WEIGER

2007

1

32. Registra Signature

Registrar

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

FREDERICK MD-00678

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show a or 28a-f show t be notified at

**Examiner must** 

"natural", or

permit. Pages 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any Injury or other traumatic event, the Medical Exar

**Physician** 

altimore, Maryland 21215-0036

Director

Funeral

\$

Completed

Be

ဥ

Examine

Physician/Medical

þ

Completed

Be

မ

Certification:

Medical

State

strar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 26

To the Funer	To the Hospl	(	To the Hospl within 24 hour
--------------	--------------	---	-----------------------------

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 11. 20.2007 DS1738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24435 MERVELL DEAN RD, HOLLY WOOD, MD 20636 AUNG 32. ORIGINAL

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 6

Pigistrar's Signature

DHMH 17 Rev 1/2001

State Registrar 2. Registrar's Sig

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Mar		epartment of Certificate of		and Me		giene, Reg. No.	2007	39451
		Registrar  1. Decedent's Name (First, Midd	fle, Last)				Douin	2	. Date of De			3. Time of Death
Physici		George Allan I	Tizer					N	Month ovemb	Day er 28		9:45 A <sup>M</sup>
/Medio		4a. Facility Name (If not institution		number)		4b. City, Town,	or Location of		0 7 0 1110		County of Dea	
		123 Deer Park	Hotel Ro	ad		Deer	Park			Ga	arrett	
Funeral		5. Social Security Number	6. Sex 1 M □ M 2 □		(In yrs. last birt	Months Days		24 Hrs. 8. Min.	. Date of Bir (Month, Da	rth ay, Year)	9. Bir	thplace (State or Foreign ountry)
Director		214-46-3458	N_IW Z	61		rs.		A	pril			st Virginia
land		Usual Residence of Decedent  10a. State 10b. County	y	1	I0c. City, Town	or Location						10d. Inside City Limits
Mary f sho	ρ	MD Gar	rett		Deer H	Park						1 ☐Yes 2X No
n the r 28a notii	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Co	ountry?
th wit 23a o 1st be		123 Deer Park I	Hotel Roa	ad		21550				Unit	ted Sta	ites
r dear	Funeral	11. Marital Status	12. Was I	Decedent Ev	er in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Original	igin? (Specif	fy Yes or No	)-	14. Race - Ame Black, Whit	
s afte	by Ft	1X Never Married 2 Ma	If Yes	es 2 <b>X</b> No , Give		1 □ Yes 2 <b>X</b> □ No			, ,		Specify:	
hours fural		3 ☐ Widowed 4 ☐ Divorce	o Year o	or Dates:	169	Decedent's Usual Occi	unation				Wh nd of Business	ite
in 72 in 72 in 72	Completed	(Specify only high	est grade complet		î	(Give kind of work done life. DO NOT use retire	e durina mosi	t of working		TOD. KII	id of pusifiess	moustry
l with jiene.	E	Elementary/Secondary (0-12) 12	Colleg	je (1-4or 5+)		orker				Baus	sch & L	omb
othe vent,	BeC	17. Father's Name (First, Middle	e, Last)		,		18. Mothe	er's Name (F	First, Middle	, Maiden	Surname)	
uld be Wenta rrked tric e	일	Charles Fizer					Vir	rginia	Shaf	fer		
e, Inda yian id 2 12 13 13 13 13 13 13 13 13 13 13 13 13 13		19a. Informant's Name/Relation	ship (Type. Print)		19b.	Mailing Address (Stree	et and Numbe	er or Rural F	Route Numb	er, City or	r Town, State, .	Zip Code)
and and m 27		Susan Coddingto	on, Siste	er		)2 Shenadoa	h Ave.					
Pages 1 and 2 should bent of Health and Men nt: If item 27 is marke ny or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal fr	om State	20b. Place of cemeter	Disposition (Name of y, crematory or other pl	lace)	Date	e	20c. Lo	cation - City or	Town, State
t. Pag tmen tant:		4 □ Donation 5 □ Other (			Cumber	land Crema			/07	Cur	nber1an	d, MD
permit. Pages 1 Department of F Important: If ite any injury or ot		21. Signature of Funeral Service	e Licensee	T. C		22. Name and Add David A 21 N. S	. Burd	lock F	unera	1 Hon	ne, P.A	. • . 0
AV THE		23a. Part1. Enter the disease, of shock, or heart failure. Lis			ne death. Do n						כנוג עוי	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition				STIL CORO					100	Onset and Death
/Medical		resulting in death)			consequence of			OHX	acour	LYSE	400	ogeza S
Examiner		Sequentially list conditions,	b									
e e sit	iner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 Due	to (or as a t	consequence o	ň).						
xecut and I-tran	Examin	that initiated events resulting in death) Last	c	to (or as a	consequence o	nn:						
cate be executed physician and the burial-transit					-	•						
ficate g phys	edical		d				-					
The law requires that the death certific the has been signed by the attending page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome pf	pregnancy	000				2	23d. Date of de	livery
deatl deatle	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 <u>□</u> Pi	regnant at tii	Fetal death me of death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	icy				Month	Day Year
ires that the de signed by the a	hys	9 🗆 Unknown		nknown								
es tha	by F	Part II. Other significant condit	tions contributing t	to death but	not resulting in	the underlying cause g	iven in Part I.					o the cause of death?
w require been sig should b									10	Yes 2[	]No 3∏P	robably 4.2 Unknown
has be	Completed								24a. Was auto	psy	prior to	utopsy findings available completion of cause of
The cate h	S								perfo 1⊟ Yes	ormed? 2 No	death? 1 ☐ Yes	s 2 □ No
Iclan Sertifi ector	Be	25. Was case referred to medic examiner?	al Hospital:					of Death (C	Check only	one)		
Phys this	2	1 Yes 2 No 27. Manner of Death		Inpatient ate of Injury	2 TER/Out 28b. T	patient 3 DOA		rsing Home	5 Resi		Other (Spe	ecify)
ding h. After fune	tion	1 Natural 5 ☐ Pendi	/8	Month, Day		ijury Wo	ork? □Yes 2□I		a. Describe	now trijury	y occurred	
Atten deat actor: y the	fica	3 ☐ Suicide 6 ☐ Could	d not be	lace of injury	- At home, far	m, street, factory, office			. Location (	Street and	d Number or R	ural Route Number,
al or safter	Certification	4 ☐ Homicide determ	b	uilding, etc.	(Specify)				City or To	wn, State)	)	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medica	I Examiner: On the	ne basis of e	xamination and	death occurred at the						
o the rithin 2 o the control of the control or the comple	Medical	one) 29b. Signature and title of certifi		nanner state	u.	29c. Licer	nse number			29d. Date	e signed (Moni	th, Day, Year)
FSFō		Da. 0 A	20	· 0	Q. Da	O AS	1. 1 5	3 (1		11	78	177
J			14	VIA								
	9	30. Name and address of person	n who completed	ause of dea	th (Item 23a) (1	Type, Print)	<u> </u>	> 1		- (	0 .	OF
	6	Paul Day	niel	Mille	V DO	Type, Print) 69WcH	Acres	s Dr	Oak	chy	din	107120
Sta Registr	ite	30. Name and address of person  31. Date filed (Month, Day, Year  NOV 2	niel 1	cause of dea	V DO	Type, Print) 69 WCH	Acres	s Dr	Oak	chy	din	107120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician NOVEMBER 21, 2007 9:25 A **GOLDBERG** M. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ROCKVILLE MONTCOMERY CASEY HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min, (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Numbe 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days 1 X M 2 □ F October 15, 1919 Washington, DC 88 Director 577-12-6545 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show at 1 X Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified Director Maryland Montgomery Gaithersburg the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. United States of America 20878 110 Chevy Chase Street, #103 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1944-1 ☐ Yes 2 🕱 No 2 white 3 ☐ Widowed 4 ☐ Divorced 1946 "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Effenbach Lena ပ Goldberg Abe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 110 Chevy Chase Street, #103 Gaithersburg, MD 20878 Reeva S. Goldberg, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 11/25/2007 Olney, Maryland 22. Name and Address of Facility 21. Sign ture of Fyneral Service I Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** MEMINGIOMA WITH SEIZURES /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): attending physician pe Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant death o 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2□ No 24a. Was an autonsy performed? 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cother (Specify) 1 Yes 2 No

Box 68760 P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

funeral director, Certification: after death. filled in by within 24 hours at To the Funeral D

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0064615

29c. License number 29d, Date signed (Month, Day, Year)

November 22, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rockville, MD 20855 6001 Muncaster Mill Road, M.D., Genevieve Wroblewski,

State Registrar

29a. Certifier

(Check on one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) NOV 26



6

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		-	_	artment of							00150	•
			1 - State Registrar AMEND#22per1		,BMW,MbCc	Cei	rtificate of	Death				200	1		)
	Physicia	an	Decedent's Name (First, Middle,							2. Date of Dea	Day			3. Time of Death	
• •	/Medic	al 🖁	Aloysius Carı				4b. City, Town,	er Leoption		Novembe		County of D		6:15am	_
*	Examin	er	4a. Facilify Name (If not institution, 10900 Rockvil		umber)			Bethe:	_			ontgon		7	
	Funeral			6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Yea	r If Under	24 Hrs.	8. Date of Birl (Month, Da		9.1	Birthol	ace (State or Foreign	_
	Director		216-20-8346	1 <b>X</b> M 2 □ F	8	2 Yrs.	Months Days	s Hours	Min.	Jan. 1			Count. lary	vland	
466	pu ,		Usual Residence of Decedent		100.0	City, Town or Lo	oation			<u></u>			10	d. Inside City Limits	_
	aryla shov	'n	10a. State 10b. County		100.	Sity, Town of Lo	cation						"	1 ☐ Yes 2 🖾 No	
	the M 28a-f notifie	Director	Maryland   Montgo	omery		North B	ethesda 10f. Zip Code				10a. Citi	zen of What	Count	rv?	_
	with ga or t be r	ā	10900 Rockville	Pike			208					USA		.,	
	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Ind Mental Hyglene. In the Medical Examiner must be notified at umatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Decedent of	Hispanic Or	igin? (Sp	ecify Yes or No	-	14. Race - A			-
0	after or ite	Ē	1 <b>X</b> Never Married 2  Marrie	Armed F	orces? 2 ☐ No sive		lfYes, specify Cu 1 □ Yes 2 <b>XX</b> No			Hican, etc.)		Black, W	,		
	ours iral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:	MMTT						Specify: V			
2	"natu	Completed	15. Decedent' (Specify only highes		)	16a. Dece	dent's Usual Occ kind of work don DO NOT use retii	upation e during mos	st of work	ing	16b. Ki	nd of Busine	ss/Ind	ustry	
7	withir ene. than he Me	ш	Elementary/Secondary (0-12)		(1-4or 5+)		holic Pr				D.	eliaic			
2	filed Hygi other ent, tl		17. Father's Name (First, Middle, L		) <del>T</del>	Lau	HOTIC FI		er's Nam	e (First, Middle,			jus		-
2	lid be lental ked c	To Be	John T. Galv	/in, Jr.				Me	rced	es Smit	h				
	should be should be man		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Stree	et and Numb	er or Rui	ral Route Numb	er, City o	r Town, Stat	e, Zip	Code)	_
, <u>M</u>	and 2 saith a n 27 is er tra	3	Richard S. McCo	ouch, SJ/	/Superv	isor 10	900 Rock	ville							
ore,	of He	i	20a. Method of Disposition 1 X Burial 2 □ Cremation	3 □Removal from	I	. Place of Dispo cemetery, crei	sition (Name of matory or other p	lace)		Date	20c. Lo	ocation - City	or To	vn, State	
	Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Sp	ecify)			k Cemete			7/2007		dstock			
Dallillion	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	0	22	2. Name and Add 500 Univ	ress of Facili rersity	y Bl	vd., We	st	FIRE	E-FL	HE	
	40 E 6 6		23a Part1 Enter the disease or	complications that	caused the de	eath Do not ent	Silver S	Spring	MD cardiac	20901	rrest		170	Approximate	
		, N	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final				or the mode of a	y ig, 00011 ac	o di dido	or roop, alony a	11001			Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		ose si								-	48 hrs	_
	Examiner				,	cancer							1	5 yrs.	
7		ner	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a cons	equence of):									
?	ecuter	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	,		·						-		_
0/00,	ficate be executed physician and is the burial-transit	Ē	rosuling in doutily Edoc	Due to	o (or as a cons	equence or):									
ò	physi physi the t	dical		d											-
X	The law requires that the death certificate has been signed by the attending late has been signed by the attending loage 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, o	utcome pf preg	nancy						23d. Date of	delive	rv	
00 00	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2□Fe gnant at time o		⊒Ectopic pregnar ⊒ Other (specify)					Month		Day Year	
	t the oby the archec	hysi	9 ☐ Unknown	9□Unk	nown										_
ν̈́ L	ss tha gned I	by P	Part II. Other significant conditio			esulting in the u	nderlying cause (	given in Part	I.					e cause of death?	
ecords,	equire en siç ould b	per l	Coronary Art	ery Dise	ease					1 🗆	Yes 2	No 3	] Prob	abiy 4 □Unknown	
ວ	law r as be	Completed								24a. Was	osv	prior	to cor	osy findings available npletion of cause of	
_ =	The page	Con								perfo 1⊟ Yes	rmed? 2 X No	deat	h? Yes	2□ No	
110	tclan: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:					e of Dea	th (Check only o	one)				_
5	Phys this (	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1	] Inpatient 2 e of Injury	ER/Outpatier	IL JUDOA		ursing He	ome 5 🙀 Resi 28d. Describe			Specify	")	_
5	ding h. After funer	tion	1 Natural 5 Pending	(Mo	onth, Day Year)		W	ork? □Yes 2□	]No	zou. Describe	now injui	ry occurred			
JIVISION	Atten deat octor:	fica	3 ☐ Suicide 6 ☐ Could n	ot be 28e, Plac	ce of injury - At	home, farm, sti	reet, factory, offic			28f. Location (	Street ar	nd Number o	r Rura	I Route Number,	
Ś	s after	Certification:	4 ☐ Homicide determi	- buil	ding, etc. (Spe	вспу)				City or To	wn, State	<i>⊒)</i>			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical (		g Physician: To the											
	o the //thin ; o the omple	Mec	29b. Signature and title of certifier	anu ma	amer stateu.		29c. Lice	nse number			29d. Da	ite signed (N	lonth,	Day, Year)	-
	7 +1	Ī	6 M	1.0-		•		32610		,	Nove	mber 2	3,	2007	
		i	30. Nam- and addr + s of person v	who completed car	use of death (If	tem 23a) (Type,	Print)	-		29					
			Thomas J Mcnamar	a 19735			,Germant	own, I	MD 20	0874					
			1 m = 1 m + 44 - 11 m + 16 - 11	224	anietrar's Sig	-Dotum									

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Catherine Rose Giuffrida 21 2007 /Medical Nov. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Caribbean Breeze Nursing Home</u> Huntingtown Calvert 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🏋 F Director 90 5/12/1917 140-05-7085 NJ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mines. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD Prince Georges West Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 Luray Place Funeral 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bicentennial Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant Commission 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Joseph Puglisi Josephine Mazzio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Giuffrida/son 12th St., NE, Washington, D.C. 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/26/07 Silver Spring, MD Gate <u>of Heaven</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Raymond-Wood F.H., P.A. 800 PO Box 430, Dunkirk, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NRUMBRIA WEBICS /Medical Due to (or as a consequence of) HAMET PALLURA-CNESTIVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No IBRILATION. 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria after death.

Director: After this within 24 hours a

To the Funeral C

completely filled

29b. Signature and title of certifier

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

-0062090

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

and manner stated.

32 CON ROAD - HONTINGTOWN MD-20639 ISNIEWSIU 32. Registra Signature 31. Date filed (Month, Day, Year)

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day, Year)

NOV 29

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSP (10/5)

0

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician:

Certification: To filled in by Funeral edical 29a. Certifier 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 11/19/2007 completed cause of death (Item 23a) (Type, Print) Annapolis, 31. Date filed (Month, Day, Year) gistrar's Signature NOV 21 2007 Registrar **ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

Linda Steele Grave		State State	of Maryland /	Depart	ment of ficate of	Health Death	and Men	tai Hyg		No. OO	07 2015
	Re	gistrar Decedent's Name (First, Middle,Las	t)	Certii	ilcate of	Death			Reg. Date of Death		3. Time of Death
Physician/ Medical Examine		Decedent's Name (1 list, Middle, 200		Stee1	e Grav	es			Month D November 2	ay Year 1, 2007	1503 hrs
Wedical Examine		a. Facility Name (if not institution, giv		Decer	4	b. City, Tov	m, or Location	of Death		4c. County of Dea	th
		3505 B Hopeland Road				Frederi	ck			Frederick	
Funeral	5.	Social Security Number 6. Se	ex 7. Age	(In yrs. last	birthday)	If Under			8. Date of Birth (	MM/DD/YYYY) 9. B Fore	ion
Director	1,	17 // /069	M 2 X F	61	Yrs.	Months	Days Hours	s Min.	Feb, 1,	1946 C	Country Maryland
		217-44-4868 1 L									10d. Inside City Limits
any	1	0a. State 10b. County		10c. City, T	own or Location	on					1 Yes 2 X No
<u> </u>	١,	Maryland F <u>rede</u>	rick	Frede	rick						
the Maryland a or 28a-f sh tified at one	1	0e. Street and Number				10f. Zip C	ode		10g	. Citizen of What Co	ountry?
the N tiffied	5	3505 B Hopeland F	≀oad				21704			Jnited Sta	ates
r death with the Maryland or items 23a or 28a-f show must be notified at once. Firmeral Director	1	Marital Status	12. Was Decedent		. 13. Was	s Decedent	of Hispanic Or Cuban, Mexica	igin? (Sped n, Puerto R	cify Yes or No- ican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
nr iter	5	1 Never Married 2 X Married	1 Yes 2	X No		-				Specific TT	
s after ral", o	~		d If Yes, Give Year or Dates:		1	_	No specify ccupation (Give		rk done T	Specify: Who	
hours Exam		15. Decedent's Education (Specify of	College (1-4 or 5		during m	ost of work	ng life. DO NO	T use retire			
16 n 72 nan ". iical 1		Elementary/Secondary (0-12)	College (1-4 or s	3+)	τ	lomema	kor		Ì	Own Hor	me
5-0036 ed within 72 hour lygiene. other than "natu he Medical Exan	<u>.</u>	12 7. Father's Name (First, Middle, Las	t)		1	TOMEMA	18.Mothe	er's Name (	First, Middle, Ma	aiden Surname)	
215- be filed nital Hyg riked of ent, the		·					Fran	nces	Souders		
21215-0036 out do be filed within 7 d Member 1 Higher 6 and refer than file event, the Medica	<u>-</u>	Chester Leroy Ste 19a. Informant's Name/Relationship (	Type, Print )		19b. Mailing	Address	(Street and Nu	ımber or Ru	ıral Route Numb	per, City or Town, St	ate, Zip Code)
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nett of Health and Mandal Hygiers and an antural", or items 23a or 28a-fisher in other fraumatic event, the Medical Examiner must be notified at once To Be Completed by Filmeral Director	-	William K. Graves	s/ Husband		3505 I	3 Норе	eland R	oad,	Frederi	ck, Maryl	and 21704
and and Health		20a. Method of Disposition			lace of Dispos ematory or ot		e of cemetery,		Date	20c. Location - City	or Town, State
TOF ages 1 nt of 1 t: 1f	ŀ	1 Burial 2 X Cremation 3					torium	Inc 1	1/25/07	Frederic	k, Marvland
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygeriand Interportant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Donation 5 Other Specifical Service Lice		)	22.1	Vame and	Address of Faci	lity 1 H	ome P.	Δ .	
Ba Perm Depr Imp	\ -	10/11/41	11/1mink		1 1 6	521 O	nossumt	own P	ike. Fr	ederick.	Maryland21702
Physician		23a. Part I. Enter the disease, or con	plications that caused	the death.	Do not enter t	he mode o	f dying, such as	cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Medical		failure. List only one cause on Immediate Cause (Final disease	<sub>a.</sub> Intral-oral gunsi	hot woun	nd						Death
aminer		or condition resulting in death)	Due to (or as a cons								
		Sequentially list conditions,	b		),						
	힐	if any, leading to immediate cause. Enter Underlying Cause.	Due to (or as a cons	sequence or	). 						
1	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of	):						
cuted			d								
50, te be executed ysjcian and burial - transit	edical	UNPENDED	AMENDED							23d. Date of del	ivon
760, icate be physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	ome of pregi		etal death	3 Ecto	opic pregna	ncy	Month	Day Year
Box 6876( e death certificate the attending physelefor use as the b	Physician/N	past 12 months?		at time of de		other (Spec				1	
Sox death	Ş	1 Yes 2 No 9 V Unkno	0111111111111								e to the cause of death?
O. B at the d by the dached		Part II. Other significant condition	s contributing to dea	ath but not re	esulting in the	underlying	cause given in	Part I.			Probably 4 Unknown
ires that the signed by signed by	d b								24a. Was		re autopsy findings available
Records,  The law require ficate has been si , page 2 should b	Completed								autop	sy prio	r to completion of cause of
e law te has	틹								1 <b>✓</b> Yes		Yes 2 No
ii Th		25. Was case referred to medical	T				26.Place of Dea		only one)		
/ita /sicia nis cer direct	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	tient 2	ER/Outpatie	nt 3 🔲 [	OA Other	Nursir	ng Home 5	Residence 6	Other: Scene
of Vital ng Physician After this cert	-1	27. Manner of Death	28a. Date of In (Month, Day FOUND:	njury /.Year)	28b. Time o	f Injury	28c. Injury at W		28d. Describe Subject sho	how injury occurred ot self	
ion tendin leath. tor: A		1 Natural 5 Pending 2 Accident Investig	Nov 21, 200	07	FOUND: 1455 hrs		1 Yes 2		,		Oite
Division tal or Attendii us after death. "al Director: Alled in by the fu	Certification:	2 Accident Investig 3 ✓ Suicide 6 Could r	28e Place of	Injury - At h	ome, farm, str	eet, factor	, office building	etc.	or Town 5	State)	or Rural Route Number, City
Divolute a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pours after a pour	ert	4 Homicide determi	1-777						-	land Road, Frede	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director.		29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of	my knowled	ige, death occ	curred at the	e time, date and	d place, and	d due to the cau	se(s) and manner as and place, and due	s stated. e to the cause(s)
o the	edical		ner: On the basis of ex and manner state	d.	and/or investig					29d Date signed	(Month, Day, Year)
F \$ F 3	Ĕ	29b. Signature and title of certifier	· -			29	c. License num O.C.M.E.	IDGI		November 2	
		hij h	w. m	·			U.U.IVI.E.			1.070111001 2	_,
0		30. Name and address of person w	ho completed cause o	of death (Iter	n 23a) I Donn Str	oet Ralt	imore, MD	21201			
1			t Medical Examin		hure #4	Joi, Dall					
Sta	ate		6 200	trar's Signat	S. A	part					

"natural", or items 23a or 28a-f show adical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or how any injury or other trainment.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

signed by the attending physician be detached for use as the buria Division or Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 25, 2007 Ethel Ann Goodman 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harmony Hall Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Days 1 □ M 20X F 170 26 8202 73 Dec. 3, Pennsylvania 1933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6726 Groveleigh Dr. 21046 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify Specify: White 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide/Special Ed. Howard County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elwood Brown Edith Lehman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Ann Haines/daughter 6626 Seneca Dr. Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 11/29/2007 | Ellicott City, MD 21. Signature of Funeral Service Licenses 201442 22 Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ATHEROSCIEROSIS years disease or condition resulting in death) Due to (or as a consequence of): Monus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): PERIPHERAL VASCULAR Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an death? 1□ Yes 2 No 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Other (Specify Asst. Lvg.1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Spepte MD. D0053150 26 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA SANTIAGO ROAD SUITEIO COUPTA 9650 Shakun M ALA 4012 am 31. Date filed (Month, Day, Year) 32. Rehistrar's Signature State NOV 2 6 2007

DHMH 17 Rev 1/2001

Registrar

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie 17 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 730 Day Month Year **Physician** pulah Visamia 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Transitions Health Care Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1♥M 2□F Yrs Director 215-14-6092 Aug 29 1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r then "natural", or items 23e or 28a-f ehow the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No Howard Marriottsville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Rt. 2, Box 47 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by Specify. 3 ♥ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer State of Maryland or other treumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other treumstic event 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Kah1 Carrie Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7201 Ridge Road, Marriottsville, MD Carolyn Brewer, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 □ Donation 5 □ Other (Specify) Garrett Memorial Gardens 11/29/07 Oakland, MD 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licensee Eathern Surface Funeral 1 Land No. Second St., Oakland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or back line. 21 N. Second St., Oakland, MD 21550 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ementia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1 Yes 20 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 in by the funeral 28b. Time of Injury 28c. Injury at Work? Certification; 27. Manner of Death 28d. Describe how injury occurred Director: After 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. MO Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Stone 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 29 Registrar 200

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				1 For State			and / Dep		t of H	ealth a		lental Hyg	iene	07	39460
5			- 2	Registrar  1. Decedent's Name (First, Middle	a Lasti			rincare	01 1	Jean		2. Date of Deat	h		3. Time of Death
12		Physici	an	RUTH	VIAL	TT	OGUE					Month	Day 24	Joo7	0332AM
1		/Medio		4a. Facility Name (If not institution			UGUE	4b. City.	Town, or	Location of	f Death		-	unty of Death	
X		Examir	ıer				non her			VISBUT				Moonk	
13		Funeral	24	Teninsum Regio 5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday,	If Under	1 Year	If Under	4 Hrs.	8. Date of Birth (Month, Day,	16 )	9. Birtho	place (State or Foreign
0,		Director		219-12-2597	1 □ M 2 🖔 F		82 Yrs.	Months	Days	Hours	Min.	FEB. 7,	1925	Loui	SYLVANIA
X	1,2,0	O		Usual Residence of Decedent											
		nylan	_	10a. State 10b. County		10c.	. City, Town or L	ocation						1	10d. Inside City Limits 1    Yes 2   No
0		e Ma	cto	MARYLAND WICC	OMICO		SALISBU	JRY							
The Contraction of the	\	hours after death with the Maryland tural', or Itema 23a or 28a-f ehow at Examinar must be notified at	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizer	of What Cour	ntry?
70,	J	ath w	rai	820 TRESSLEE					1801					JSA	
0		er de	une	11. Marital Status	12. Was Dec	orces?	n U.S. 13.	Was Deced If Yes, spec	lent of Hi ify Cuba	spanic Orig n, Mexican,	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
7	36	s afte	by F	1 ☐ Never Married 2 ☐ Marri 3 🔀 Widowed 4 ☐ Divorced	If Vac Gi	ve		1 ☐ Yes 2	2 <b>X</b> No	Specify:			Sp	ecify: Wi	HITE
63	Ş	hour tural	edt		t's Education	,a.to3.	16a. Dece	dent's Usua	I Occup	ation			16b. Kind	of Business/in	dustry
10	15	in 72 n " na	Completed	(Specify only highe	st grade completed)		(Give	kind of wor DO NOT us	k done d	turina most	of worki	ing	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,
	212	with piene r the	E	Elementary/Secondary (0-12)	College	1-4or 5+) •		HOMEM	AKEI	}			O	N HOME	
	b	filed Hyg othe	BeC	17. Father's Name (First, Middle,	Last)					18. Mother	r's Name	(First, Middle, M	Maiden Su	mame)	
	a	henta henta rked tic ev	To B	JOSEPH	McNAUGH	ITON	VIA	L		RU	JTH	ME	RRIA	1	
	Maryland 21215-0036	2 should be f and Mental F ie marked of aumatic eve.	Γ.	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mail	ing Address	(Street	and Numbe	r or Rura	al Route Number	City or To	own, State, Zip	Code)
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturat", or itema 23e or 28e-f ehow eny injury or other traumatic event, the Madical Examinat must be notified at once.		THEODORE M. HOO	GUE/SON		28065	NANT	ICOK	E ROA	D, S	SALISBUR	Y, MI	21801	
	Baltimore,	ss 1 a of He item		20a. Method of Disposition	2 D	,	b. Place of Disp cemetery, cre	osition (Name	ne of ther plac	θ)		Date	20c. Loca	ion - City or To	own, State
	E	Page nent of int: if		1 ☐ Burial 2 🔯 Cremation 4 ☐ Domanion, 5 ☐ Other (S			REMATORY	OF D	ELMA	RVA 1	11/2	5/07	DELM	AR, DEI	AWARE
	ä	permit. Departn Imports eny inju		21. Signatur vot Funeral Service	Licenses /	0	2	2. Name an	d Addres	s of Facility	у				
	m	8 8 8 8		1 Karles L	& Hair	Sq.						ME, SELB		LE, DE.	19975
				23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the c	leath. Do not en	ter the mode	e of dyin	g, such as o	cardiac c	or respiratory arre	est,		Approximate Interval Between
	7	Physician		Immediate Cause (Final disease or condition	, , , , , , , , , , , , , , , , , , , ,	1	-Ispinat	ک دید		emo					Onset and Death
		/Medical		resulting in death)	Due to		sequence of):		Y	00.00	. [ , ,				
		Examiner		Sequentially list conditions	b										
		D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a con	sequence of):								
		ocuter nd trans	Examiner	that initiated events	C										
	760,	e be executed /sicien and e burial-transit		resulting in death) Last	Due to	(or as a con	sequence of):								
	876		lical		d										
	Box 68	The law requires that the death certifical ate has been signed by the ettending phroage 2 should be detached for use as the	Physician/Med	IF FEMALE:										J	
	30,	ath co	lan/	23b. Was decedent pregnant in the past 12 menths?		birth 2 🗆 f	Fetal death 3	□Ectopic pr					230	<ol> <li>Date of deliving</li> <li>Month</li> </ol>	ery Day Year
	P.O.	the e	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟ Preg 9□ Unkr	nant at time nown	of death 5	Other (sp	өспу)						
	9.	hat It od by detac		Part II. Other significant condition	ons contributing to a	leath hut not	resulting in the	underlying ca	ause civi	en in Part I		23e. Did tot	acco use	contribute to t	he cause of death?
	ds,	signe	d by	•	<b>-</b>		3	,	3			1 □ Ye	s 2 🗆 f	No 3 ☐ Prol	bably 4 Unknown
	0	requ	Completed									A. 116			
	3ec	sician: The law certificate has b irector, page 2 s	Idm									24a. Was a autops perform	V	prior to co death?	opsy findings available impletion of cause of
	alF												No	1 🗆 Yes	2□ No
	Vit	ysician: is certific director.	Be	25. Was case referred to medica examiner?	Hospital:	,			Oth	20		n (Check only on			
	o	Phys this ral di	To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date		2 ER/Outpatie		8c. Injun	4 🗀 Nu		me 5 Reside			<i>(</i> y)
	n o	ding h. After fune	tion	1 ☑Natural 5 ☐ Pendir	ng (Mor	ith, Day Yea	(r) Injury	M	Worl	<br Yes 2 □ f		200. 2000/120 110	,,,,,,,,,	0001100	
	18	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	not be 290 Plan	e of Injury - /	At home, farm, si					28f. Location (St	reet and h	lumber or Run	al Route Number,
	Division of Vital Records,	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	4 ☐ Homicide determ	build	ling, etc. (Sp	pecify)	,,	, 011100			City or Town			
		spite lours lerai		29a. Certifier 14 Certifyii	ng Physician: To th	e best of my	knowledge, dea	th occurred	at the tin	ne, date an	d place,	and due to the ca	ause(s) ar	d manner as	stated.
		e Ho 24 h e Fu	Medical		Examiner: On the b										
	_	ro th within ro th	Me	29b. Signature and title of cedifie	n			290	Licens	e number		2	9d. Date s	igned (Month,	Day, Year)
	f			11000	el L				Hoo !	5619	`		11/241	100	
7		ren		30. Name and address of person	who completed cau	se of death	(Item 23a) (Type		.,		-				
		0		206-4	A Colon	Do	400	EASH		home	1	- Salul	> M	218	( د
		Sta		31. Date filed (Month Bay Y2)	6 2007 32.1	gistrar's S	ignature	1							
	413	Regist	rar		- 2001	Mu	N. A.	porte	_						

			. For	State of Maryland				Mental Hyg	jiene	
			State Registrar		Cer	tificate of l	Death	,	eg. No.2	39461
	Physicia		1. Decedent's Name (First, Middle, Last)					Date of Dea     Month	Day Year	3. Time of Death
	/Medic		James Theodo		n			Novembe		
	Examin	er	4a. Facility Name (If not institution, give str			Cilia	Location of Death	1	4c. County of Dea	
76g.			Peninsula Regional M 5. Social Security Number 6. Sex	edical Center		If Under 1 Year	#Under 24 Hrs.	8. Date of Birth	Wicom 9.Bi	rthplace (State or Foreign ountry)
	Funeral Director			<sup>M 2□F</sup> 81	Yrs.	Months Days	Hours Min.	(Month, Day 4/5/192	7, Year) C 26 W:	isconsin
-	الكلمانية المراكد		Usual Residence of Decedent				11			
	rylan how		10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	e Ma 8a-f s etiflec	Director	Maryland Wicomico	Sa	lisbur	<u> </u>				A
:	a or 2 be no	Dire	10e. Street and Number 310 Millpond Land	e. Ant 170		10f. Zip Code 21804			I0g. Citizen of What C USA	oundy?
	is 23a must	Funeral		2. Was Decedent Ever in U.S	i. 13. V	Vas Decedent of H		pecify Yes or No-		erican Indian,
	r Iter d	Fun	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 No If Yes, Give	'	f Yes, specify Cuba	an, Mexican, Puert	o Rićan, etc.)	Black, Wh	
3	ursa mal', o	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: <b>Army</b>		I∐Yes 2 <b>K</b> No	Specify:		Specify:	white
	72 ho natur sical	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wor	king	16b. Kind of Busines	s/Industry
7	ithin ne. han " e Mec	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		house pri	nting
7	lled w dygie <b>her t</b> l		12 17. Father's Name ( <i>First, Middle, Last</i> )		pair	nter	18. Mother's Nan	ne (First, Middle,	house pai	ilcing
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	) Be	Olaf Hanson				Margar	et Yunkh	err	
	shoul nd Me mark imati	2	19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailir	g Address (Street	and Number o <u>r</u> Ru	ıral Route Numbe	r, City or Town, State	Zip Code)
M	Health ar		James Hanson/son		310	Umbarger	Dr., Be	l Air, M	ID 51012	
נו	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	CA	ace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location - City of	or Town, State
	Pages ment of H ant: If ite ury or of		4 □ Donation 5 □ Other (Specify)			y Cremato		3/07	Salisbury	MD
	permit. Departn Imports any Inju		21. Signature of Funeral Service Licenses		$\wedge$	2. Name and Addre	Funeral	Home Pro	fessional	Association
			220 Port 1 Enter the disease or complic	ations that days of the death	Do not ent	501 Snow	Hill Rd.	, Salisc	oury, MD 2	Approximate
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	/ 1	1 /	9,	,	,	Interval Between Onset and Death
j. G	hysician /Medical		disease or condition resulting in death)	Due to (or as a consequ		tate (o	neer			
	Examiner		h.	Chronic C	obstr	active f.	ulmona	er 2 1/	sease	
R.	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):	/		0		
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
5	icate be executed physician and the burial-transit	al E		240 10 (01 40 4 001 004	01,00					
000	ficate phys s the	edical	d.							
Š	n certi nding use a	N/U	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome pf pregna		75-1			23d. Date of c	,
0	death e atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		∃Ectopic pregnanc ∃ Other (specify) _	у		Month	Day Year
5	at the by th	hys	9 ☐ Unknown			7		00- Did 4	-1	to the sauce of dooth?
<u> </u>	es the		Part II. Other significant conditions cont	7		elletüs	en in Part I.	23e. Dia 1	\$1	to the cause of death?  Probably 4 ☐ Unknown
colus,	een s	ted	Insulin Dependo	m. Diaber	5 ///	e Lu ms				
בֿ	e law has b e 2 sh	Completed by			-			24a. Was autor		autopsy findings available o completion of cause of
<u> </u>	r. The							1□ Yes	2 No 1 □ Y	
<u> </u>	siclar certif recto	Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatier	nt 3 DOA Oth	ner	ath (Check only o		nanif d
5	Physer this eral di	: To	27. Manner of Death	28a. Date of Injury	28b. Time o	-			dence 6 Other (S) now injury occurred	Jecny)
5	nding ath. r: Afte	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 No			
	r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
5	ital o									and the state of
	Hosp 24 hou Fune Fune	Medical	29a. Certifier  (Check only one)  Certifying Physical (Check only one)	ician: To the best of my knower: On the basis of examinal and manner stated.	wledge, deat tion and/or ir	h occurred at the to estigation, in my	ime, date and plac opinion, death occ	e, and due to the curred at the time,	date and place, and o	as stated. Iue to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and Pompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	29b. Signature and title of sertifier	and marinor oscioo.		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
	"NUP"		) (then)	Mo		25	14127		11/2	3/07
(	NR TO		30. Name and address of person who cor		23a) (Type,	Print)	1		11/2	1/
			Alon DAVIS MO	100 Power	1 St.	Sal19	shury	MC	218	04.
	04.	ate	31. Date filed (Month Day Year)	32. Sgistrar's Signa	tur	Cart !	1			

Registrar

	_1	For State Registrar	<u>-</u>	Certific	cate of Dea	ith	Reg.	. No. 200	7 391,6
Physicia /Medic	in al	1. Decedent's Name (First, Middle, Last)  James Oliv		rison		/	Month Variables	Day Year 17 200	7 22:46
Examin	e1	4a. Facility Name (If not institution, give s Pln/1941/A Reg 10 NAC	undiani no	10		sbury		4c. County of De	1/0
Funeral Director		214-30-8936	7. Age (In yrs. last to 73	hirthday) If U Yrs. Mor		nder 24 Hrs. 8 urs Min.	Date of Birth (Month, Day, Y 2/15/19	9. B 33 M	irthplace (State or Fore Country) aryland
Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		Usual Residence of Decedent  10a. State  10b. County		wn or Location	l		-		10d. Inside City Lim 1 ☐ Yes 2 🛣
a or 28a-f be notifie	× -	Maryland   Wicomico 10e.Street and Number 7426 Austed Lane	) Sall	isbury 10	f. Zip Code 21801		10g	. Citizen of What (	Country?
ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, The Medical Examiner must be notified at	by Funera		2. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Army Year or Dates:		Decedent of Hispan, specify Cuban, Me	ic Origin? (Speci exican, Puerto Ri ecify:	fy Yes or No- can, etc.)	Black, Wi	nerican Indian, nite, etc. hite
ne. nan "natura e Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	eation 16	Sa. Decedent's (Give kind of life. DO No	Usual Occupation of work done during OT use retired)	most of working	'	Sb. Kind of Busines	s/Industry .kerson Cor
	Be	12   17. Father's Name (First, Middle, Last) Oliver James Harri	Lson	CONSUL	18.	Mother's Name (	First, Middle, Ma		.Xerbon co.
t Health and Menta Item 27 Is marked other traumatic ev	<u>م</u>	19a. Informant's Name/Relationship (Ty) Mary Harrison/wife		9b. Mailing Ad 7426 A	dress (Street and Nusted Lar	lumber or Rural ne, Sali	Route Number, C sbury, [	City or Town, State	e, Zip Code)
ant: If		20a. Method of Disposition 1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	emoval from State	sbury C	(Name of y or other place) rematory	unkno	own	Salisbu	cy, MD
Departr Importa any inju		21. Signature of Funeral Service License	Gener (FSP)						Association 1804
igned by the attending physician and Medical camine transit be detached for use as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ce of):					Interval Between
the attending poshed for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death	ath 3□Ecto	opic pregnancy er (specify)			23d. Date of Month	delivery Day Yea
signed by Id be detad	d by Phys	Part II. Other significant conditions con Metastatic		g in the underl		Part I.			e to the cause of deat Probably 4 \(\_\)Unki
cate has been si page 2 should	Completed						24a. Was an autopsy perform	prior	
ath. r: After this certificate ha e funeral director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation		/Outpatient 3	DOA Other: 2	□ Nursing Hon		) nce 6 ⊡Other (5 w injury occurred	Specify)
urs after de eral Directo illed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of injury - At home building, etc. (Specify)				City or Town,	State)	r Rural Route Number,
within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 ertifying Phy (Check only one) 2 ☐ Medical Exam	iner: On the basis of examination and manner stated.	and/or investi	gation, in my opinio	on, death occurre	ed at the time, da	ate and place, and	onth, Day, Year)
FIRA		30. Name and address of person who co	ompleted one of death (Item 23	Ba) (Type, Print	D248	100	-0.21/-0	11/17/	. , o

		<b>Please</b> Amend PI line a-c	Type or Print in B	ack Indelible Ink. Ensure IE G883 9/23/08 TT I/ Department of Health and	All Copies Are	e Legible.
		1 - For State Registrar	- Clare of Waryland	Certificate of Death	Reg. N	<u>~2007 39463</u>
Physic		1. Decedent's Name (First, Middle, La	ast)	and.	2. Date of Death Month D	2/ 2001 1600 M
/Medi Exami		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of De	ath 4	c. County of Death
	3	Penins Ja Regiona, 5. Social Security Number 6.	Medical Center Sex 7. Age (In yrs. 18	SATIS bury st birthday) If Under 1 Year If Under 24 H	rs. 8. Date of Birth	9. Birthplace (State or Foreign
Funeral Director		220-90-2862	1 M 2□F 38	Yrs. Months Days Hours M	in. (Month, Day, Yea	69 Couintry) Md.
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits
e Mary Ba-f sh	Director	md. Word	ester Poc	omoko		1 DYes 2 No
with th	Dire	10e. Street and Number	4 4	10f. Zip Code	10g. C	Citizen of What Country?
r death ems 23 er mus	Funeral I	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by F.	1 X Never Married 2 Married 3 Widowed 4 Divorced	1	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
5-0036 72 hours af 'natural', or	eted	15. Decedent's E	Education rade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of the control of the contr		Kind of Business/Industry
d 2121 filed within Hygiene. wher than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	Do	such Rolla
nd 2 be filled tal Hyg d other	Be	17. Father's Name (First, Middle, Las	" 1	18. Mother's N	Name (First, Middle, Maide	en Surname)
Maryland 21215-0 nd 2 should be filed within 72 ho lift and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical	မှ	19a, Informant's Name/Relationship	Handy (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number City	or Town, State, Zip Code)
e, Mary 1 and 2 sho Health and em 27 is me		Alice Briddel	1 (mother)	10270 Harrison	nini	1 5 10
S to E to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from State ce	ace of Disposition (Name of metery, crematory or other place)		Location - City or Town, State
Baltimo permit. Pag Department Important: I any injury o once.	1	4 Donation 5 Other (Spec		ccdowin Man 12.  22. Name and Address of Facility	-1-07 W	astovar Md. Tilh Funeral Home
Ball permit Depar Impor	1	) VI A		19.0. Box 33/1	o comoka	nd, 21851
	2 9	23a. Part1. Enter the disease, or conshock, or heart failure. List onl		Do not enter the mode of dving, such as care ine intoxication wit	h complicati	Approximate Interval Between Onset and Death
Physician /Medical	ı	disease or condition resulting in death)	a. Due to (or as a consequ	ence of):	WED BY MEDICAL EXAMINE	1-11-11-11
Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Hypera Co.	EILE Off.	111	Jacob
executed executed in and ial-transit	Examiner	Cause (Disease or injury that initiated events	COLAINE	1845 / Su	MED BY MEDICAL EXAMINATION	
60, be executed clan and burial-transit	_	resulting in death) Last	Due to (or as a consequ	ence of):	)VC-	
Box 6876 sath certificate be attending physici for use as the bu	Physician/Medica		d	0.00		
Box eath cert attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O. I	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 Other (specify)		
- 2 p g			contributing to death but not resu	iting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 □ No 3 Probably 4 □ Unknown
cord  **require been si	eted	perior price			24a. Was an	24b. Were autopsy findings available
al Rec	Completed by				autopsy performed	prior to completion of cause of death?
or Vital Records, Physician: The law requires tribs certificate has been signeral director, page 2 should be o	Be	25. Was case referred to medical examiner?	Hospital:	Othor	Death (Check only one)	
Phys Prhys er this c	7: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Injury at	g Home 5 Residence	
Division (I or Attending Fafter death.  Director; After I in by the funer	Certification:	1.★Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ★Could not	1114 11/11/200	07 Fnd uhk 1□Yes 2X No	unk	
Division Attack	ertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc. (Specify	me, farm, street, factory, office  Nooded area	28f. Location (Street City or Town, St Pocomoke	and Number or Rural Route Number,  ate) Fnd 714 4th St.  City, MD
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to			Physician: To the best of my know	vledge, death occurred at the time, date and p	lace, and due to the cause	e(s) and manner as stated.
b the Hithin 24 or the Formplete	Medical	one)  290. Signatu and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
F 3 F 8		1/1		757331	16-	- 23-2007
17 BV		30. Name/and addies of person wh	o completed cause of death (Item	29c. License number  29c. License number  2757331  23a) (Type, Print)  540 SNON 41111 R  ure	en enischi	In mn
St	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Signat	ure	U SHUPPU	
Regist		NOV 2 6	2007 Maria.	& Soule		/

Months

7. Age (In yrs. last birthday)

94

Yrs.

Certificate of Death

4b. City, Town, or Location of Death

Crofton

If Under 1 Year If Under 24 Hrs.

Hours

Days

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

230-48-8892

Usual Residence of Decedent

Katherine Eloise Heflin

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

1 ☐ M 2 🕏 F

 $11/20/2007^{\text{Day}}$ 

4c. County of Death

10g. Citizen of What Country?

Specify:

Education

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

1 Tyes

29d. Date signed (Month, Day, Year)

208 crain HWY, SW. GlenBurnie MB 21041

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

Unknown

Month

Baltimore, MD

USA

Black, White, etc.

14. Race - American Indian,

White

Anne Arundel

2. Date of Death

8. Date of Birth (Month, Day, Year) 8/28/1913

39464

3. Time of Death

9. Birthplace (State or Foreign

Virginia

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 € No

3:10aM

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person with

31. Date liled (Month

EE,

2007

no completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Ernest Stevens Hammersley /Medical 18 2007 3:35 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1√2 M 2 🗆 F Director 223-14-2019 89 Oct 8, 1918 Virginia Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh Directo 1 ☐Yes 2 ☐ No MD Montgomery Rockville 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any lighty or other traumatic event, the Me Iteal Examinations. 10f. Zip Code 10g. Citizen of What Country? 11407 Ashley Drive 20852 USA by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 42–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3K Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Distribution Manager Newspaper 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Chancellor Hammersley 2 Emma Morton Grady 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Hammersley / Son 12508 Epping Ct., Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) Parklawn Memorial Park 11/24/2007 Memorial Park 11/24/2007 Rockville, MD 22. Name and Address of Facility Francis J. Collins Funeral Frome, Inc 21. Signature uneral Service Lix nsee 500 University Blvd., W, Silver Spring, MD20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 06 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy perform Vital 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ammersley 1 Yes Certification: To 2 No 1 🗀 Inpatient 2 ER/Outpatient 3 DOA Division or 27. Manner eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 5 Pending 1 atural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 2007 Ginchernan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chergota Olycherman 31. Date filed (Month Day)

State Registrar

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		nt of Health and te of Death		Reg. No.	39466	
	Physicia		Decedent's Name (First, Middle, Las     Brian	n Lay Hildebrand	!		2. Date of De Month	25 2007	3. Time of Death A 1 1205 M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		Town, or Location of Dec	ath M	4c. County of Death	imico	
	Funeral Director		5. Social Security Number 6. Se		t birthday) If Under Months  Yrs.	or 1 Year If Under 24 Hi Days Hours Min		y, Year) Coi	nplace (State or Foreign untry) Virginia	
500-61212 B	show date	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County	,	Town or Location		<del></del>		10d. Inside City Limits 1 ☐ Yes 2(4)No	
	or 28a-f	Directo	Maryland Carolin  10e. Street and Number	e Den		ip Code		10g. Citizen of What Co		
	be light within 7.2 flours after beath with the maryer tal Hygiene. do other than "naturel", or items 23a or 28a-1 show event, the Medical Exemitar in ust be natified at	by Funeral I	25132 Adams Landin  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	g Road  12. Was Decedent Ever in U.S. Armed Forces?  1		27629 edent of Hispanic Origin? ecrify Cuban, Mexican, Pue 2 No Specify:			e, etc.	
		To Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of w	vorking	16b. Kind of Business/		
	be filed wit tal Hygiene d other the		12 17. Father's Name (First, Middle, Last)		College De			Educati Maiden Sumame)	Con	
aryla	should and Men marke umatic		Golden Clay Var.  19a. Informant's Name/Relationship (1)	Type, Print)		ss (Street and Number or	Rural Route Numb			
é, ≥	1 an Heal em 2		Nancy S. Hildebra  20a. Method of Disposition  1 Burial 2 Cremation 3	20b. Place	25132 Add ce of Disposition (No netery, crematory or	rums Landing .  ame of other place)	Road, Der	20c. Location - City or	Town, State	
a	permit. Pages Department of mportant: If it iny injury or o		*4 □ Donation 5 □ Other (Specif)  21. Signature of Funeral Service Licen	) Capi	itol Cremo	and Address of Facility	27/2007   me. P.A.	Dover, Del		
מ	80 5 5 8		23a. Part1. Enter the disease, or compshock, or heart failure. List only		Do not enter the mo	outh Second ode of dying, such as card	Street, $\hat{L}$ iac or respiratory a	11451,	Approximate Interval Between Onset and Death	
	Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  PARKINSONS DRSRASE BND STAGE  Due to (or as a consequence of):									
vision of Vital Records, P.O. Box 687	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b						
	ite be executed iysicien and he burial-transit	cal Exa	that initiated events resulting in death) Last	c.  Due to (or as a consequence of):  d.						
	death certifics e attending ph id for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal di 4 Pregnant at time of deal		23d. Date of del Month	ivery Day Year			
	law requires that the de as been signed by the a o 2 should be detached f	by	Part II. Other significent conditions of	ontributing to death but not resulti		acco use contribute to the cause of death?				
	o	Completed						Was an autopsy performed?  Yes ➤□ No  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes ✓□ No		
	ing Physicien:	Be	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only			
		tlon: To	1 Yes No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?			<del></del>	dome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred		
	eat or:	Certification:	2 Accident 3 Suicide 4 Homicide			28I. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C								
	To the To the Comp	Me	29b. Signature and title of certifier  29c. License number  20c. License number					29d. Date signed (Month, Day, Year)		
			30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)	00058	410	1/- 2.	3-07	
₩.	Sta Begist		GHUMM WARIS  31. Date liled (Month Day, Year)	COASTAL F 32 Registrar's Signature	tospica	2 P.O BOX	1733,	SALISBU	Ry 1021212	

ORIGINAL

Brian C. Hildebrand

DHMH 17 Rev 1/2001

			For State of Maryland  1 - Registrar		artment of F rtificate of I			ene g. No.2007	39467	
В	Dharis	7	1. Decedent's Name (First, Middle, Last)  2. Date of Death					1	3. Time of Death	
	Physici /Medic		Thomas E. Holtz	November :			r 25, 2007	8:17p M		
	Examir	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death		
		- 149	Frederick Memorial Hospit  5. Social Security Number   6. Sex   7. Age (In yrs. las		If Under 1 Year	erick   If Under 24 Hrs.	9 Date of Birth	Frederick		
b	Funeral Director		218-30-8748 X X 2 F 78	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 15,	Year) 1929 Mary	nplace (State or Foreign untry) y land	
	ryland how	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits	
36	e Ma Ba-f s			ırmon	t				1 ☐ Yes 2 ☐ No	
	vith the		10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?	
	eath v		12521 Catoctin Furnace Road  11. Marital Status  12. Was Decedent Ever in U.S.	12.1	2178			U.S.A.	ican Indian	
	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show tatic event, the Medical Examiner must be notified at		11. Marital Status  1 ★ Never Married 2		f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ameri Black, White Specify:		
ğ	2 hou		15. Decedent's Education	16a. Deced	ient's Usual Occup	ation	1	6b. Kind of Business/Ir		
21	filed within 72 Hygiene. hther than "na ent, the Medic		(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	during most of worki )	ng			
21	led wi lygien her th nt, the		7	Su	pervisor			Canning Fa	ictory	
and	ntal H ed ot		17. Father's Name (First, Middle, Last) Thomas R. Holtz			18. Mother's Name Helen M.		,		
Baitimore, Maryland 21215-0036	2 should and Mer is marke aumatic			10b Mailin	a Address (Street			1 City or Town, State, Zi	(- O-d-)	
	es 1 and 2 should by Health and Meni fitem 27 is marked rother traumatic		Glenn Cool / Nephew	5249 <del>-</del> 0	G Wigvill	e Road, I	hurmont,	, MD 21788	p Code)	
	iges 1 nt of He If item or oth				sition (Name of natory or other plac			0c. Location - City or T	own, State	
	:. Pages tment of tant: If it		4 □ Donation 5 □ Other (Specify) Mt.			tery 11/2		ewistown, M		
ğ	permit. Pag Department Important: any Injury once.		21. Sign the of Faheral Service Lifensee	RŐ1 615	Name and Addres BERT E. D 5 EAST MA	ÄILEY & S IN ST., T	ON FUNER	RAL HOMES, MD 21788	P.A.	
	Physician	ıer	23a. Part 1. Enter the disease, or complications that deuse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between							
) 34 11			Immediate Cause (Final disease or condition resulting in death)  a. MYCARDIAL ISCHEMIC Onset and Death WOUS							
	/Medical Examiner		Due to (*r as a consequer	ice of):						
	incate be executed physician and sthe burial-transit		Sequentially list conditions, if any, is a consequent b. Due to (or as a consequent	ics of):						
		Examiner	Sequentially list conditions, if any, isability to immediate cause. Enter Underlying Cause (Disease or injury that initiated events continued by the conditions of the conditi							
Š	e exe ian ar urial-t	EX	resulting in death) Last  Due to (or as a consequer	ice of):						
5876U,	tificate be executed g physician and as the burial-transit	edical	d							
XOD	n certific nding p use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnance					23d. Date of delivery		
	e death he atten led for u	Physician/IV	in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ He past 12 months?  4 ☐ Pregnant at time of deat		Ectopic pregnancy Other (specify)			Month	Day Year	
Ţ.	that the ed by 1 detach	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to t	the cause of death?	
ecords,	requires that the een signed by th nould be detache	ed by	Color Comment					3 2 No 3 Probably 4 Unknown		
	The law r ate has be page 2 sh	Completed					24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of	
<u>ק</u>	an: T tificat tor, pa		25. Was case referred to medical			26. Place of Death		√No 1 ☐ Yes	2 □ No	
_	iysici iis cer direc	To Be	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER	/Outpatient	3 DOA Othe			ce 6 □Other (Specia	ifu)	
5	ng Pł		27. Mann of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work?  28c. Injury at Work?  28d. Describe how injury occurred Work?							
	tendi leath. tor: A the fu	cati	2 Accident investigation M 1 Yes 2 No							
	al or A s after o	Certification:	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)						al Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours aftererest. To the Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)							
	within To the	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
			A.Z. HEGAZI		Du	+4151	t	11-26	-07	
(	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A. Z. H. C. H. C. H. C. B. Thomas Johnson Drive; FREDERICK MD 21702  31. Date filed (Month Pay, Year), 2007  32. Jegistrar's Signature							
	Sta Registra		31. Date filed (Month Day, Year) 2007 32. Jegistrar's Signature	Ap	orte					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** November 23, 2007 | 10:17 P M William Max Herndon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. Jan 27, 214-28-7749 79 1928 Virginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland | Montgomery Damascus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8600 Gue Road 20872 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Public Elementary/Secondary (0-12) College (1-4or 5+) School System Boiler Mechanic 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Τ. Lucy McNeally George Herndon ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Savanna Rimbey - Daughter 103 Prospect Road, Mount Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Howard Chapel Cemetery 11/28/07 Mount Airy, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Faneral Service License Molesworth-Williams P.A., Funeral Home 20872 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** enns /Medical insequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes Division or Vital the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 P/Outpatient 3 DOA ပ 1 Tes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Iniury 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 124 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 32. Registra

29c. License number

29d. Date signed (Month, Day, Year)

			Please	Type or Prin			ndelible Ink. artment of F				•	е.	
		for State Registrar		State Of Ivid	aryiaiiu		ertificate of			Reg. No		7	39469
Physic	oion	1. Decedent's Nam	e (First, Middle, La	ast)					2. Date of De			ear	3. Time of Death
/Med			Eugene				45 O'ts Town	1 1 1 1	Novemb				1:30 P. <sup>M</sup>
Exam	iner		fnot institution, giv .y Acres	ve street and number)			4b. City, Town, o	r Location of Dea ike Park		40	:. County of D Garret		
Funera	ī	5. Social Security N	umber 6.	Sex 7. Ag	e (In yrs. las	st birthday		If Under 24 Hr Hours Min	s. 8. Date of Bi	rth av. Year	9.		ce (State or Foreign
Directo		232-54-7	092	1XM 2□F 73		Yrs.	IVIOITIIS Days	riouis iviii	Oct. 9				
land ow		Usual Residence of 10a. State	10b. County		10c. City,	Town or L	ocation					100	d. Inside City Limits
Mary a-f sh ified	itor	MD	Garret	t	Mtn	. Lak	e Park						1 X Yes 2 No
ith the	Director	10e. Street and Nu	mber				10f. Zip Code				tizen of Wha		•
eath w Is 23a must I	Funeral	285 Shad	y Acres	Lane	Ever in U.S.	13	21550	lispanic Origin?	Specify Yes or N		ted St		
S after d or item			ied 2 X Married	Armed Forces?	No		Was Decedent of H		erto Rican, etc.)		Black, V		
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural" or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	db	3 ☐ Widowed	4 Divorced	If Yes, Give Yeer or Dates:			1 ☐ Yes 2 🛣 No	Specify:				√hit	
"netu	Completed	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)		(Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of w	orking	16b. k	(ind of Busine	ess/Indu	istry
2121; ed within 7/giene. er then ", t, the Med	dwo	Elementary/Seco	ndary (0-12)	College (1-4or 5	5+)		trician	-7		We	stvacc	)	
o filed al Hyg other	Be C	17. Father's Name	(First, Middle, Las	t)				18. Mother's No	ame (First, Middle	e, Maidei	n Surname)		
aryland should be in and Mental is marked o	Jo.		Matson						n V. Lor				
re, Maryland s 1 and 2 should be file f Health and Mental Hy item 27 is marked oth other traumatic event		19a. Informant's N			LII fo		Shada Aca						
		20a. Method of Disp		Herndon,	20b. Pla	ce of Disp	Shady Acr osition (Name of ematory or other place	1	Date		ocation - City		
			☐Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State			n Gift Re	i i	11/28/07	Mo	rganto	wn.	WV
Baltimo permit. Page Department of important: If eny Injury or once.		21. Signature of Fu	neral Service Lice	nsee			22. Name and Addre David A.	ss of Facility					
0 83E55		Kath	unine !	Socition			21 N. Se	cond St	Oakla	nd.	MD 215	50	
		23a. Part1. Enter t shock, or hea Immediate Cause		pplications that caused one cause on each lin	the death.	Do not er	nter the mode of dyir	ng, such as cardi	ac or respiratory a	arrest,			Approximate nterval Between Onset end Death
Physician /Medical		disease or condition resulting in death)	n a	a Due to (or as	a conseque	nce of):	12mol	1000	Ne				1
Examiner		Conversion line to a conversion line	n dikiona	h	,	,	type t	Du	`				CITZ
p ti	iner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, nmediate orlying	Due to (or as	a conseque	nce of):							17
50, be executed cian and ourial-transit	Examiner	that initiated events resulting in death)		c	a conseque	nce of):						+	
	-		•	d									
rtificate being physicias the bu	Physician/Medica	IF FEMALE:											
BOX 6	ian/	23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth	2 Fetal d	eath 3	□Ectopic pregnanc	/			23d. Date of Month		y Day Year
at the de by the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnant at 9□Unknown	t time of dea	ith 5	☐ Other (specify) _						
<u> </u>	by Ph	Part II. Other signi	ficant conditions	contributing to death be	ut not result	ing in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribu	te to the	cause of death?
ecords, law requires t es been signe 2 should be o	ed b		tu	lungy	Huy	er.	tensin		. 10	Yes 2	!□No 3□	Proba	bly 4 tonknown
lecc law r les be	Completed				(				24a. Was	psy	prior	r to com	sy findings available pletion of cause of
				T					1□ Yes	ormed?	deat		No
VITAI sician: s certifical	o Be	25. Was case refer examiner? 1 ☐ Yes 2 ☐		Hospital:	ent 2∏FI	R/Outpatie	ent 3 DOA Oth	or:	Home 5 Res	-	6 □Other (a	Specify)	-
On Or ding Phys h. After this funeral dii	n: To	27. Manner of Deat	h	28a. Date of Inju	iry 2	8b. Time			28d. Describe			opecity)	
SIOF endin path. or: Aff	atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigatio	n	, , , , ,			Yes 2 □ No					
DIVISION OF  I or Attending Phy after death. Director: After this i by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined		ury - At hom c. <i>(Specify)</i>	e, farm, s	treet, factory, office		28f. Location (			r Rural i	Route Number,
UNISION OF VITA To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier		hysician: To the best									
the Ho in 24 h the Fu ipletely	Medical	(Check only one)	2 ☐ Medical Exe	miner: On the basis of and manner sta		on and/or i			curred at the time				
With To 1	Σ	29b. Signature and	title of certifier	110			29c. Licens	e number	>	29d. Da	ate signed (M	fonth, D	ay, Year)
		20 Nome and add	TO 1000 01 november 1	completed cause of d	leath (Itom 3	3a) /Tunn		1355		- 1	120		
13	8	DC TVC	533 OI PEISOII WHO	MUSEU CAUSE OI O	311	C)	Forth	St (	akla	6	MD		31220
	tate	31. Date filed (Mon	th, Day, Year)	2 8 7007	ans Signatu	re	Angello	,					
Regis			1104		CONTRACT OF THE		19						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Inahalli Revanaradhya November 24,2007 12:29 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year)
Sept. 2,1934 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Hours 1X M 2□ F 73 India

10c. City, Town or Location

Davangere

10d. Inside City Limits

29d. Date signed (Month, Day, Year)

Rockville, MD

24,2007

1 ☐ Yes 2 No

**Funeral** Director

**Physician** 

/Medical

Examiner

Usual Residence of Decedent

10b. County

None

10a. State

India

Director Funeral þ Completed Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and be detached for peen : has certificate Hospital or Attending Physician: this filled in by the funeral To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

Division or Vital Records, P.O. Box 68760

Examiner Physician/Medical þ Completed Be Certification: To ical

29a. Certifier

(Check only one)

Manish

31. Date filed (Month, Day, Year)

certifier

Gambhir

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29b. Signature

10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 577004 India 2965 6th Main M.C.C. 'B' Block 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Gangamma Inahalli Puttappa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18409 Autumn Field Court Boyds MD. 20841 Swaroop Aradhya 20b. Place of Disposition (Name of cemetery, company nother place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 30, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Davangere, India Veerashaiva, 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr. Gaithersburg, MD 20877 1 RACY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Malignant Arrhythmia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2X ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 9901

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Negligate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOO61415

Medical Center Drive

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Milton W. Iglehart 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M M 2 □ F Months Days May 7, 219 12 4908 84 1923 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11990 Hallshop Road 21029 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 If Yes, Give 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 1942–46 Specify 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bricklayer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Iglehart Mary Susan Baldwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton H. Iglehart/Son 12000 Hallshop Road Clarksville, MD 21029 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) St. Mark's Episcopal 11-26-2007 Highland, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24a. Was an autopsy perform

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

ģ

Completed

Be

MD

ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

and 2 should be filed within 72 hours after death in leath and Mental Hygiene. In 27 is marked other than "natural", or items 23

Health tem 27 I

Pages 1

Department of Healt Important: If item 2 any injury or other

Baltimore, Maryland 21215-0036

burial-tran the as use for

The law requires that the death certificate be executed

Box 68760,

o

۵

Records,

Division or Vital

or Attending

hours after death.

Examiner physician Physician/Medical attending Ś þ Completed peen has certificate Be P After t Medical Certification: To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ☐ 1□ Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 hpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) Mariner of Death 1 Dillatural 2 DAccident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number UD 57131

le AVE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print 7501

MARIC 31. Date filed (Month, Day, Year) NOV 2 6

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Poistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nov. 21, 2007 6:40a M Emile Fred Jabara /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct. 14, 1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 559-38-3081 1 ★M 2 ☐ F 78 China Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Kirkdale Road 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1948 – Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Intercept in mortant: if item 27 is marked other than "natural"; or Item any injury or other traumatic event, the Madicinian once. Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 🛣 No Specify: Completed by 1951 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Executive Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Farid E.Jabara Alyce Jabara ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Jabara/Son 9010 Kirkdale Road Bethesda, Md. 20817 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 □ Removal from State Chesapeake Crem. 11/23/2007 Beltsville, Md 4 □ Donation 5 ☐ Other (Specify) 21. Signature f Funeral Sei PHILIP Con That DI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis unknown /Medical Due to (or as a consequence of): Examiner Metastatic Melanoma unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by o ⊏**X**No Be Certification: To Medical

BUIDT GHO AM Division or Vital Records, P.O. Box 68760 SABARA

the burial-tran attending ph within 24 hours after death.

Very the Funeral Director: After the Completely filled in by the funeral

with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

"natural", or items 23a or 28a-f shov clical Examiner must be notified at

												10163 2		4 DOUNTOWN
												24a. Was an autopsy performed? 1∐ Yes 2⊠ No	death?	etion of cause of
25.	Was case referred to r examiner?	medical _							26.	. Place of Dea	th (C	Check only one)		
	1 Yes 2 No		Hospital:	1 XInpatient	2 🗆	ER/Outpatient	3□	DOA	Other:	4 ☐ Nursing H	lome	5 🗆 Residence	6 ☐Other (Specify)	
	2 Accident	Pending investigation		Date of Injury (Month, Day Ye	ear)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 □ No	280	d. Describe how inju	ry occurred	
		Could not be determined	28e.	Place of injury - building, etc. (S	At ho	ome, farm, stree	t, fact	ory, o	ffice		28f	Location (Street as City or Town, State	nd Number or Rural Ro e)	ute Number,
29	a. Certifier 1 XC	ertifying Phy edical Exam	/sician: 1	To the best of m	y kno amina	wledge, death o	occurr	ed at t	the time, o	date and place on, death occu	e, and	d due to the cause(s at the time, date an	) and manner as stated d place, and due to the	i. cause(s)

29b. Signature and title of certifier

29c. License number D0062999 29d. Date signed (Month, Day, Year) Nov.21,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd.Bethesda, Md 20814 Petek Donmez MD

31. Date filed (Month, Day, Year) State Registrar

NOV 26 2007



5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, **Physician** Month DOROTHY DORENE JACKSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs./last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 📉 47 Yrs. 216-70-5750 Director 06-20-60 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notifled at Director L⊟Yes 2 No MD BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2113 TUCKER LN APT C 3 or Items 23a 21207 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give XX. 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced BLACK 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if item 27 is marked other than "any Injury or other traumatic event, the Mean once. Elementary/Secondary (0-12) College (1-4or 5+) RESULTS TECHNICIAN QUEST DIAGNOSTICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISAAC H. TILGHMAN JR. BARBARA JONES ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA DAVIS 9675 MELVIN WHITE RD DEAL MOTHER ISLAND, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOHN WESLEY UMC CEM. 12-01-07 DEAL ISLAND, MD 22. Name and Address of Facility
BENNIE SMITH FUNERAL HOME 21. Signature of Fun ral Service Licensee 917 W ISABELLA ST SALISBURY, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examine and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial. Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25 cu has autopsy performed 1 Yes 2 No r this certificate he ral director, page funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place/of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Japatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospitar ... within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Recruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

och

601

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

r d a

31. Date filed (Month, Say, Year) NOV 2 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Day Susie C. Jetters Nov. 21,2007 10:05p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital 7703 Surratta Rd. Clinton Prince George If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 6/17/1921 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 578-30-3681 1 ... M X X Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Exa<u>miner must be notified at</u> Md. Prince George 1 □Yes XXNo Director Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12200 Windbrook Dr. 20735 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11th Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental William Rollins Cora Bush injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau Frances Jeter 12200 Windbrook Dr, Clinton, Md. 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State St. Stephens Cem. 11-28-07 Milford, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Cedell Brooks Funeral Home mo 1325 P.O. Box\_11 Port Royal, Va. 22535 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Theumon Lowy /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (c) as a co | e uence of) physician Physician/Medical use IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy perform 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hin 24 hours after death. the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 29a. Certifier

Records, P.O. Box 68760. Division or Vital ō Hospital

hours after

within 72

Maryland

Baltimore,

Pages '

within To the

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7700 Old Branch Ave. Clinton, Maryland 20735 Berwa, MD 31. Date filed (Month, Day, Year) NOV 2 6 2007

Medical

(Check only one)

-CXMI

			1- For State Of Mar Registrar		artment of Health and I rtificate of Death		711117	39475
			Decedent's Name (First, Middle, Last)		Timodio of Bodin	Reg. 2. Date of Death	No.	3. Time of Death
	Physici		William Robert John	nson			Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	15011	4b. City, Town, or Location of Death	Novembe	r 27 2007 4c. County of Death	5:20P
	LAGIIII	ei						
	Funeral		Ruxton Health of Denton  5. Social Security Number 6. Sex 7. Age (	(In yrs. last birthday)	Denton If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Caroline 9. Birthol	ace (State or Foreign
	Director		218-12-1378 <sup>1</sup> X <sup>M 2□ F</sup> 85		Months Days Hours Min.	(Month, Day, Ye	ar) Count	n) land
	to		Usual Residence of Decedent			10	· · · · · · · · · · · · · · · · · · ·	Tana
	ylan how			Oc. City, Town or Lo			10	d. Inside City Limits
	a Ma	Director	Maryland Caroline	Den	ton			1 ☐ Yes 2 🌠 No
	or 28	ire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	ry?
	be tiled within 72 hours after death with the Maryland ital Hygiene. so other then "natural", or tiems 23e or 28e-f show event, it is Medical Examinar must be notified at	ai	420 Colonial Drive		21629		USA	
	eep dea	Funerail	11. Marital Status 12. Was Decedent Eve Armed Forces?		Was Decedent of Hispanic Origin? (Si	pecify Yes or No-	14. Race · America Black, White, e	
9	after or It	/Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		1 ☐ Yes 2 ☐ XNo Specify:	Jindan, Glo.,		
21215-0036	ural',	d by	3 Widowed 4 Divorced Year or Dates:				Specify: B1	.ack
5-	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of won	king 16b	Kind of Business/Ind	ustry
2	within ene.	п	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired)			
	tiled v Hygie other t		0 7  17. Father's Name (First, Middle, Last)	Far	m Worker		agricultu	re
and and	be that He of	Be	_		_	ne (First, Middle, Maid	en Sumame)	
Maryland	s 1 and 2 should be if Health and Mental item 27 is marked other treumatic ev	ဥ	Robert Johnson	401 44 111	Elsie			
Na	12 sh h and 7 is m freum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru		y or Town, State, Zip	Code)
d)	s 1 and 2 of Health item 27 i		Dallas Johnson/ brother	PO be 20b. Place of Dispo	ox 4; Bridgevi		Ware 19 Location - City or Tox	
کّور	in it of I		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other place) nan Cemetery 12			
Ë	t. Pa rtmer rtent rjury		4 □Donation 5 □ Other (Specify)	1		/ 02/07	Goldsbor	5, MD
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot		21. Signature of Juneral Service Licensee	F	Name and Address of Facility  leegle and Helt			,
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ent	or the mode of dying, such as cardiac	or respiratory arrest,	MD 21632	Approximate Interval Between
	Physician		Immediate Cause (Final	ronar	y antery d	risease		Onset and Death
	/Medical			consequence of):	y arriery a	Case		years
П	Examiner		Saguantially list conditions					
	P #	ner	Sequentially list conditions, b. b. cause. Enter Underlying	onsacuarios of):				
	nd trans	Examiner	Cause (Disease or injury that initiated events					
Ö,	e exe	Ä	resulting in death) Last Due to (or as a c	onsequence of):				
8760,	cate be executed physician and the burial-transit	dical	d				-	
9	E 0.8		IF FEMALE:					
Вох	that the death certiting of by the attending of detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of deliver	
P.O.	0 0 0	Sici	1 Yes 2 No 4 Pregnant at tim		Other (specify)		Month I	Day Year
٧.	at the	Phy	a Curuomu					
а.	= 000	-				11		
	res tha igned be del		Part II. Other significant conditions contributing to death but in				o use contribute to the	
	requires een sign		Cerebro Vascular			4		cause of death?
	faw requires as been sign 2 should be					1 Yes 24a. Was an	2 No 3 Proba	bly 4 Unknown
Records,	The law requires ate has been sign page 2 should be					1 Yes	2 No 3 Proba	bly 4 Unknown sy findings available pletion of cause of
Records,	cien: The law requires ertiticate has been sign ctor, page 2 should be	Completed	Cerebro Vascular  25. Was case referred to medical		n F	1 Yes 24a. Was an autopsy performed	2 No 3 Proba	bly 4 Unknown sy findings available pletion of cause of
Records,	hysicien: The law requires his certilicate has been sign I director, page 2 should be	Be Completed	cerebro Vascular		26. Place of Deal	1 N Yes  24a. Was an autopsy performed 1 Yes 2 U I	2 No 3 Proba  24b. Were autop prior to comdeath? No 1 Yes //	bly 4 □Unknown sy findings available pletion of cause of 2□ No
Records,	v requi	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 28a. Date of Injury.	2□EP/Outpatien   28b. Time of	26. Place of Deal	24a. Was an autopsy performed: 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 No 3 Proba  24b. Were autop prior to comdeath? 1 Yes 2  6 Other (Specify,	bly 4 □Unknown sy findings available pletion of cause of 2□ No
Records,	ending Physicien: The law requires eath. or: After this certiticate has been sign the tuneral director, page 2 should be	To Be Completed	25. Was case referred to medical examiner?  1	2□EP/Outpatien   28b. Time of	26. Place of Deal t 3 DOA Other: 4 Nursing Ho	24a. Was an autopsy performed 1 Yes 2 1 1 1 Yes 2 1 1 1 Yes 2 1 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes	2 No 3 Proba  24b. Were autop prior to comdeath? 1 Yes 2  6 Other (Specify,	bly 4 □Unknown sy findings available pletion of cause of 2□ No
Records,	Attending or death. ector: After by the tune	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	2 ER/Outpatient 28b. Time of Injury	26. Place of Deal t 3 DOA Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	24a. Was an autopsy performed 1 Yes 2 1 th (Check only one) ome 5 Residence 28d. Describe how in	2 No 3 Proba  24b. Were autopprior to comdeath? 1 Yes: 6 Other (Specify, jury occurred	bly 4 □Unknown sy findings available pletion of cause of 2 □ No
	or Attending tter death. Director: Afte in by the tune	Certification; To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Noulder investigation  3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (c)	2 ER/Outpatient ear) 28b. Time of Injury At home, farm, stre	26. Place of Deal  t 3 DOA Other: 4 Nursing Ho  28c. Injury at Work? M 1 Yes 2 No  eet, factory, office	24a. Was an autopsy performed 1 Yes 20 th (Check only one) ome 5 Residence 28d. Describe how in City or Town, Str	2 No 3 Proba  24b. Were autop prior to com death? No 1 Yes : 6 Other (Specify, jury occurred  and Number or Rural ite)	bly 4 □Unknown  sy findings available pletion of cause of  2□ No  Route Number,
Records,	or Attending tter death. Director: Afte in by the tune	Certification; To Be Completed	25. Was case referred to medical examiner?  1	2 ER/Outpatien  28b. Time of Injury  At home, farm, stre  Specify)  ny knowledge, death tamination and/or inv	26. Place of Deal  t 3 DOA  Other: 4 Nursing Ho 28c. Injury at Work?  M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed 1 Yes 2 1 th (Check only one)  ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Street and due to the cause	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes 2  6 Other (Specify, jury occurred  and Number or Rural ite)  (s) and manner as sta	bly 4 Unknown sy findings available pletion of cause of 2 No  Route Number,
Records,	or Attending tter death. Director: Afte in by the tune	To Be Completed	25. Was case referred to medical examiner?  1	2 ER/Outpatien  28b. Time of Injury  At home, farm, stre  Specify)  ny knowledge, death tamination and/or inv	26. Place of Deal  t 3 DOA  Other: 4 Nursing Ho 28c. Injury at Work?  M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed 1   Yes 2001   1   Yes 2001   28d. Check only one) ome 5   Residence 28d. Describe how in 28f. Location (Street City or Town, St. and due to the cause red at the time, date a 29d. I	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes:  6 Other (Specify, jury occurred  and Number or Ruralite)  (s) and manner as stand place, and due to Date signed (Month, E	sy findings available pletion of cause of Poute Number,  Ited.  I
Records,	Attending or death. ector: After by the tune	edical Certification; To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 1 Acident 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (Acident (Check only one) 1 Certifying Physicien: To the best of manner stated	2 ER/Outpatien  28b. Time of Injury  At home, farm, stre  Specify)  ny knowledge, death tamination and/or inv	26. Place of Deal t 3 DOA  28c. Injury at Work? M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed 1   Yes 2001   1   Yes 2001   28d. Check only one) ome 5   Residence 28d. Describe how in 28f. Location (Street City or Town, St. and due to the cause red at the time, date a 29d. I	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes 2  6 Other (Specify, jury occurred  and Number or Rural atte)  (s) and manner as stand place, and due to	sy findings available pletion of cause of Poute Number,  Ited.  I
Records,	or Attending tter death. Director: Afte in by the tune	edical Certification; To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 1 Acident 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (Acident (Check only one) 1 Certifying Physicien: To the best of manner stated	2 ER/Outpatien  28b. Time of Injury  At home, farm, stre  Specify)  my knowledge, death tamination and/or invitation.	26. Place of Deal  t 3 DOA  Other: 4 Nursing Ho  28c. Injury at Work?  M 1 Yes 2 No  eet, factory, office  coccurred at the time, date and place, restigation, in my opinion, death occur  29c. License number  D 00 4 7 5 3 4	24a. Was an autopsy performed 1   Yes 2001   1   Yes 2001   28d. Check only one) ome 5   Residence 28d. Describe how in 28f. Location (Street City or Town, St. and due to the cause red at the time, date a 29d. I	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes:  6 Other (Specify, jury occurred  and Number or Ruralite)  (s) and manner as stand place, and due to Date signed (Month, E	sy findings available pletion of cause of Poute Number,  Ited.  I
Records,	or Attending tter death. Director: Afte in by the tune	edical Certification; To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury (Month, Day Young) building, etc. (A.)  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and title of certifier and manner stated  29b. Signature and title of certifier 3.	2 EP/Outpatien ear) 28b. Time of Injury At home, farm, stre Specify)  my knowledge, death tamination and/or inv th.  th.  th.  th.  th.  th.  th.  th.	26. Place of Deal  t 3 DOA  Other: 4 Nursing Ho  28c. Injury at Work?  M 1 Yes 2 No  set, factory, office  coccurred at the time, date and place, restigation, in my opinion, death occur  29c. License number  D 00 4 7 5 3 4	24a. Was an autopsy performed:  1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Yes	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes:  6 Other (Specify, jury occurred  and Number or Ruralite)  (s) and manner as stand place, and due to Date signed (Month, E	sy findings available pletion of cause of Poute Number,  Ited.  I
Records,	or Attending tter death. Director: Afte in by the tune	Medical Certification; To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. (Acceptable of the Could not be determined 29e. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death  31. Date filed (Month, Day York)  32. Registure as	2 EP/Outpatien ear) 28b. Time of Injury At home, farm, stre Specify)  my knowledge, death tamination and/or inv th.  th.  th.  th.  th.  th.  th.  th.	26. Place of Deal  t 3 DOA  Other: 4 Nursing Ho  28c. Injury at Work?  M 1 Yes 2 No  eet, factory, office  coccurred at the time, date and place, restigation, in my opinion, death occur  29c. License number  D 00 4 7 5 3 4	24a. Was an autopsy performed:  1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 1 Yes 2 Yes	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes:  6 Other (Specify, jury occurred  and Number or Ruralite)  (s) and manner as stand place, and due to Date signed (Month, E	sy findings available pletion of cause of Poute Number,  Ited.  I

## 10d. Inside City Limits 1X Yes 2 No 10g. Citizen of What Country? United States 14. Bace - American Indian. Black. White, etc. White 16b. Kind of Business/Industry Men's clothing store 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Approximate Interval Between Onset and Death 2 wat 2 works 23d. Date of delivery Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: spital or Attendi nours after death. neral Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 25. 2007 JJ.57\_ D (8019 ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST MAGERSTOWN MD 21740 DATTA 340 32, Registrer's Signature 31. Date filed (Month, Day, Year) State mark. NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 39477 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>.03</sup>30, 2007 **Physician** Thomas Dale Jenkins November 10:20 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 894 Foster's Inn Rd. Grantsville Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 30, 5. Social Security Number Birthplace (State or Foreign
 Country) 7. Age (In vrs. last birthday) <sup>Year)</sup> 1951 **Funeral** Days Hours 1 M 2 □ F Maryland 215-56-8636 56 Yrs. June Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 894 Foster's Inn Rd. 21536 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then eny injury or other traumatic event, the Mu Elementary/Secondary (0-12) College (1-4or 5+) Coal Truck Driver 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Jenkins Leotta Witt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen L. Jenkins/Wife 894 Foster's Inn Rd., Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 4, 2007 Grantsville, MD Trinity Cemetery 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensie Humale P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death shock, or heart ailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) rostute May /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for it Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only ong) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) 29c. License mumber 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) 10

DHMH 17 Rev 1/2001

State Registrar Char

31. Date filed (Month, Day, Year)

ORIGINA

4th street

32. Registrar's Signature

10.

			For State	State of Ma	aryland		artment of I rtificate of			ntal Hy		0.0.0	7 0	017
			Registrar  1. Decedent's Name (First, Midd	lle. Last)			Tuncate of	Deali		. Date of De	Reg. No.	200	1 3	me of Death
	Physici		Murray	Kaye						Month November	Day			45 A M
, in	/Medic Examir		4a. Facility Name (If not institution				4b. City, Town, o	or Location		NOVEMB		County of De		43 A
	LAGIIII		11400 Strand	d Drive, #302			Rockvill	.e				Montgom	erv	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birthday,			r 24 Hrs. 8 Min.	Date of Bir (Month, Da	th	9. B	irthplace (S	tate or Foreign
65	Director		237-10-4388	1 <b>X</b> M 2□F	93	Yrs.	World Days	Tiours	J	une 5	191	L4 Né	country) W Yor	k
	land		Usual Residence of Decedent  10a. State 10b. County	у	10c. City,	, Town or L	ocation						10d. Ins	de City Limits
	Mary f sh	to	Maryland Mon	tgomery		N.	Bethesda						1 🗷	Yes 2□No
	r 28a	irec	10e. Street end Number	e gome Ly		2, 4	10f. Zip Code				10g. Citiz	zen of What (	Country?	
	h with	JE D	11400 Strand	Drive #30:	2		2	20852		į	Jnite	ed Stat	es of	Ameri
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	<b>Funeral Director</b>	11. Marital Status 1 □ Never Married 2 🛣 Mar	12. Was Decedent I Armed Forces? 1 X Yes 2 1		6. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No			fy Yes or No can, etc.)	)-	14. Race - An Black, Wh		an,
21215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	d Year or Dates:	1943-				· 					
5-	"nati	lete	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	st of working		16b. Kii	nd of Busines	s/industry	
12	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 Is marked other than "natu or other traumatic event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		iness Own				F	Paper F	Recvc1	ing
	filed Hygother ent, 1	Be C	17. Father's Name (First, Middle	, Last)		- 540			ner's Name (i	First, Middle		•		
lan	lid be fenta rked tic ev	To B	Leo Kamins	ky				I	Esther	Berns	stein	ı		
Maryland	12 should be filed w h and Mental Hygie 7 <b>Is marked other ti</b> rraumatic event, <u>th</u>		19a. informant's Name/Relation				ng Address (Street				-			
-	1 and 2 Health em 27 I		Nettie Kaye -	Wife			00 Strand		ve #3	02, 1	N. Be	thesda	, MD	20852
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State			osition (Name of matory or other pla		Dat		20c. Lo	cation - City	or Town, Sta	ate
Ë	Pag Iment tant: jury o		4 Donation 5 Other (		Jud		emorial (			23/07	01	lney, N	iaryla	nd
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21. Signature of Euneral Service	Licensee			2. Name and Addr		III			ineral H		
			23a. Part1. Enter the disease, o	or complications that caused	the death.		L800 New Ha					ring, M	Appro	ximate
	<b>D</b>		shock, or heart failure. Lis Immediate Cause (Final	st only one cause on each lin	ie.					,			Onset	al Between and Death
	Physician /Medical		disease or condition resulting in death)	a. Septice Due to (or as	mia	ence of):							2 0	lays
	Examiner						Failure						2 :	years
٠.	-	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	ence of):							+	
	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> c										
Ö,	e execan an an ar	EX	resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	ate be hysici	dical		d									_	
ထ	ertific ing p	Mec	IF FEMALE:											
Вох	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnanc	у			2	23d. Date of o Month	lelivery Day	Year
	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5	Other (specify) _							
P.0	that the de led by the a		Part II. Other significant condit	tions contributing to death be	ut not resul	Iting in the (	ınderlying cause gi	ven in Part	I.	23e. Did	tobacco u	use contribute	to the caus	se of death?
Vital Records,	uires tha signed I	d by	Chronic Renal	l Insufficien	су					1 🗆	Yes 2	XiNo 3□	Probably	4 □Unknown
00	w require been sign	ete								24a. Was	an	24h Were	autonsy fin	dings available
Re	he lav e has	Completed								auto perf	psy ormed?	death	?	dings available n of cause of
ta			25. Was case referred to medical	al				26 Plac	e of Death (	1□ Yes	20 No	1 🗆 Y	es 2□N	0
>		To Be	examiner? 1 ∐ Yes 2 📉 No	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatie	nt 3 DOA Ot	hor:				6 □Other (S)	pecify)	
٥.	ig Ph ter th neral		27. Manner of Death  1 Natural 5 □ Pendi	28a. Date of inju (Month, Day	ry ( Year)	28b. Time o	of 28c. Inju			d. Describe			,,	
Ö	endin ath. or: Af	atio	2 ☐ Accident invest	tigation		,		Yes 2	]No					
Division	r Atte	Certification:	3 Suicide 6 Could 4 Homicide deterr		ry - At hor c. (Specify)	me, farm, st	reet, factory, office		28	f. Location ( City or To	Street an wn, State	nd Number or	Rural Route	Number,
	oital o urs aff rral D		<b>-</b>											
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 ♣ Certifyi  (Check only one) 2 ■ Medica	ing Physiclan: To the best if Examiner: On the basis of and menner sta	examinati	vledge, dea ion and/or i	th occurred at the to	ime, date a opinion, de	and place, an eath occurred	d due to the	cause(s) , date and	) and manner d place, and d	as stated. lue to the ca	ause(s)
	Vith To t	Σ	29b. Signature and little of codifi				29c. Licen	se number			29d. Dat	te signed (Mo	onth, Day, Y	ear)
,	2		1 10 15	0//			D	36797	7		Novem	ber 21,	2007	
,	1		30. Name and address of person	1/ //			Print) od Road S	11 i t 4	1004	Reth	esda	, MD 2	0852	
	Sta	te	Dr Alan Sche 31. Date filed (Month, Day, Year	r) 32 Registra	ar's Signati	ure	ou noau b	GILE	TOUR	Dett				
	Registr		NOV 26	2007 House	1	do	enter							
DH	IMH 17 Rev 1/2	001				-								

DHMH 17 Rev 1/2001

**Physician** /Medical **Examiner** death certificate be executed and

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

other

marked

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked t any injury or other traumatic ewoore.

ould be i

Director

Completed by Funeral

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Examine as the burial-trai physician Physician/Medical attending p for use as e esn been signed by the should be detached 2 Completed page 2 has director, Be 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Certification:

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

25. Was case referred to medical

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number D0064983 29d. Date signed (Month, Day, Year) November 23, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kashif Firozni, M.D. 2101 Medical Park Drive, #200 Silver Spring, Maryland 20902

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 2 6 2007



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2007 November /Medical <u>Ronald Gail Kinsey</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Washingtion County Hospital</u> <u>Washington County</u> <u>Hagerstown</u> If Under 1 Year . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F Yrs. Director 57 Jul v 04 1950 Ohio 219-54-0504 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at Maryland Washington Boonsboro 1 □ Yes 🔏 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8815 Irma Court 21713 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23: any Injury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Owner</u> Electrical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Leon G. Kinsey Lillian L. Wolfe Kinsey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u> Carol Anne Kinsey - wife</u> 8815 Irma Court Boonsboro Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 12-1-2007 Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Musia 23a. Part1. Enter the diserse, or complications in a raus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Co Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons quence of): Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Mo ပ 1 🗌 Inpatient 2 DER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician;

14-16

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and ti

30. Name and address of person who completed

32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

and manner stated

or Red

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HAGERSTOWN

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 39481 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month  $11/18^{Day}$ 2007 William Louis Krause 11:50<sup>M</sup> /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number Date of Birth (Month, Day, Year) 1/30/1935 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 M 2 ☐ F 214-34-2753 72 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23e or 28e-f ehow MD Anne Arundel Crownsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 395 Lake Rd. 21032 USA Pages 1 and 2 should be filed within 72 hours after deeth nent of Health and Mental Hygiene. int: If item 27 ie markad other than "naturai", or items 23. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Frank Krause Sylvia Elizabeth Snyder ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health ar
important: if item 27 ie
any injury or other trau John Krause Brother 395 Lake Rd. Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 25 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 11/21/2007 Baltimore, MD 21. Signature of Funeral Service Linens 22. Name and Address of Facility Hardesty Funeral Home, P.A. 70 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** /Medical Due to (or as a consequence of) Examiner exa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cop Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes 2□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 1 🗌 Yes 2 No 1 Yes : After this certifice e funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 40 Other 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Incationt 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 24 hours efter death. 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2-mpletely Vithin 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 062242 alla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parknay JUZaune Ivan 31. Date filed (Month, Day, Year) NOV 2 1 2007 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39482 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day NOVEMBER 22 BARBARA LYNN KELLER 2007 11:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAR 31 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace *(State or Foreign Country)* West Virginia 6. Sex **Funeral** 1 □ M 2 🕅 80 Director 143-20-6655 West Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director MD Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1407 Key Parkway 21701 USA permit, Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elkridge Elementary Elementary/Secondary (0-12) College (1-4or 5+) Catonsville, MD Elementary School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Robert Keller June Gaither Keller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Frost, Friend 1407 Key Parkway, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dogation 5 DOther (Specify) Park Heights Cemetery 11/26/07 Brunswick, MD 21. Sign fure of Fun Al Service Lice Barryan AM Williams, John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardia minute /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death Day 5 Other (specify) P.O. 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 ☐Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐ Yes 2/KNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FER/Outpatient 3 □ DOA 1 Inpatient After this 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day 5 Pending investigation 1 🗌 Yes 2 🗆 No · death 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stern athleen

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

32. Regist 's Signature

2007

Physician/ ical Examiner	Registrar  1. Decedent's Name (First, Middle,Last)  Flaine					. No.	1 2 U L X
	D10111	e Lee			2. Date of Death Month November 2	201	3. Time of Death 2250 hrs
	4a. Facility Name (if not institution, give street and number) 6612 Eberle Drive, Apt. 302		4b. City, Town, or L Baltimore	ocation of Death		4c. County of Dea	ath
runeral Director	5. Social Security Number 6. Sex 7. Ag 245-15-5018 1 M 2X F	e (In yrs. last birthday) 52 Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1	(MM/DD/YYYY) 9. E	Birthplace (State or eign South Country)
any	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Locat			100222		10d. Inside City Limits
<b>*</b>	Maryland 10e. Street and Number		Baltin	more	10	g. Citizen of What Co	1 X Yes 2 No
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Manital Status 12. Was Deceden	t Ever in U.S. 13. Wa	s Decedent of Hisp			U.S.A.  14. Race - Am White, etc	nerican Indian, Black,
s after death with rral", or items 23 niner must be no by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	es, specify Cuban	specify:		Specify: B]	Lack
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed I	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)  College (1-4 or 1 2	5+) during m	nt's Usual Occupations of working life.	DO NOT use retire	ed)	House F	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)  Sylvest	er Cassid	y 1	8.Mother's Name Annie	(First, Middle, M Mae Di	xon	
MD 21.  In 2 should the and Mer in 27 is mar aumatic even	19a. Informant's Name/Relationship (Type, Print)  Inez Hancock / Sist	er 21Ma	<u>rtin Lu</u>	<u>ther Ki</u>	ng Dri	ve,Chera	ate, Zip Code) 29552 aw, S.Caroli
Baltimore, lemit Pages I and Department of Heal Important: If item injury or other tra	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from S  4 Donation 5 Other Specify:	20b. Place of Dispos crematory or of McDouga1	her place)		Date - 5 – 0 7	20c. Location - City  Laurinb	urg, S. Carol
Baltin	21. Signature of Funeral Service Licensee  McLau P May Miles  23a. Part I. Enter the disease, or complications that cause	22. 1	Name and Address	of Facility Man	rzullo	Funeral imore,M	Chapel, P.A
Physician /Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive A	d the death. Do not enter			r respiratory arre	st, shock, or heart	proximate Interval Between Onset and Death
	or condition resulting in death)  Due to (or as a constitutions, if any, leading to immediate  Due to (or as a constitutions, if any, leading to immediate)						
cuted transit							
be exe sician a urial -	d						
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bueledical Certification: To Be Completed by Physician/Meledical Certification:			etal death 3 [	Ectopic pregna	ncy	23d. Date of deli Month	very Day Year
Br.O. Bo s that the de gned by the e detached f		th but not resulting in the	underlying cause g	piven in Part I.			e to the cause of death?
Kecords, P.O.  The law requires that the ficate has been signed by 1 yage 2 should be detache Completed by PI					24a. Was a autop	sy prior med? deat	
Vital Rec nysician: The this certificate I director, page To Be Con	25. Was case referred to medical examiner?			of Death (Check	only one)	2 No 1	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the realtheath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach extification: To Be Completed by P.	1 Ves 2 No Impat	ient 2 ER/Outpatier jury 28b. Time of Year)	Injury 28c. Inju	ry at Work? Yes 2 No		Residence 6 🗹 O	other: Scene
DIVISION O Spital or Attending nours after death. neral Director: After filled in by the fune Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	Injury - At home, farm, str			28f. Location (S or Town, S		r Rural Route Number, City
DIVISION DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic		e(s) and manner as and place, and due t	stated. to the cause(s)				
To To	and manner states  29b. Signature and title of certifier	1	29c.Licens			29d. Date signed	
11.	30. Name and address of person who completed caused		0.C.		ME	November 30	, 2007
4		Medical Examiner		reet, Baltimor	e, MD 21201	1	

		·	For State Registrar	State	of Ma	arylan			te of I			іептаі Ну	giene Reg. N		7	39	481	+
	Physici	an	Decedent's Name (First, Midd									2. Date of De Month Novembe	Da		ear 107		e of Death :10 a	
13. -2.	/Medic		Davetta La  4a. Facility Name (If not institution		number)			4b. City	. Town, or	Location	n of Death	NOVEMBE		. County of I				_
1	Examin	er	4601 N. Park					,	nevy C					Mont	gome	ery		
- 4	Funeral		5. Social Security Number	6. Sex		e (In yrs. I	last birthday)	If Unde	er 1 Year	If Und		8. Date of Bir	rth	. 9.	Birthp	lace (Sta	te or Fore	ign
	Director		557-26-2369 Usual Residence of Decedent	1□M 2፟ቚF		83	Yrs.	Months	Days	Hours	Min.	(Month, Da October	14,	1924	Coun	Georg:	ia	
	yland how at		10a. State 10b. Count	у		10c. City	y, Town or Lo	cation				-			1		e City Lim	
	a-f sl	Director	Maryland Mor	tgomery				(	Chevy	Chase	2						/es 2.[○]	40
	th the	ire	10e. Street and Number					10f. Zi	ip Code				10g. Ci	itizen of Wha				
	th wi		4601 N. Park							20815					J.S.			
36	2 should be filed within 72 hours after death with the Maryland and Mental hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	rried 1 ☐ Ye	Forces?				edent of H ecify Cuba 2 No			ecify Yes or No Rican, etc.)	0-	14. Race - A Black, N Specify:	White,		1,	
2-0036	2 hour atural	ted b	15. Decede	nt's Education			16a. Dece				ant of work	ing	16b. F	Kind of Busin				
Maryland 21215	vithin 73 ane. than "n	Completed	(Specify only high Elementary/Secondary (0-12)		e (1-4or 5 5+	+)	life.	DO NOT	us <i>e retired</i> nemake	1)	ost of work	ing		Own H	lone			
7	filled \ Hygie ther	ပ္ပိ	17. Father's Name (First, Middle				1				ther's Name	e (First, Middle	, Maide	n Surname)				
an	d be antal	o Be	Meyer (	Goldberg						E	Elizabe	th Silve	rstei	in				
<u></u>	shoul nd Me mark	ှင	19a. Informant's Name/Relation				19b. Mailir	ng Addres	ss (Street	and Nun	nber or Rur	al Route Numl	ber, City	or Town, Sta	ate, Zip	Code)		
$\frac{8}{2}$	and 2 sealth ar		Elizabeth Rabir	- Daughter	ſ		6 La	ke Co	urt, R	ockvi	ille, M	lary1and	20853	3				
စ်	- i h =		20a. Method of Disposition			20b. P	Place of Disponentery, creing David					Date	_	ocation - Cit	y or To	wn, State	е	_
E O	Pages nent of I nrt: If Its iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	m State	Kin Mem	g David orial G	arden	s		11/23	3/2007	Fa1	lls Chur	ch,	Virg	inia		
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	e Licensee	+		22 H	ines-l	and Addre Rinald	i Fur	neral H	lome, Inc	ver S	Spring,	Mar	yland	20904	-
			23a. Part1. Enter the disease, shock, or heart fillure. Li	or complications the	at caused	the death										Approxi	mate Between	
3	Physician		Immediate Cause (Final disease or condition				neumonia									Onset a	and Death	
•	/Medical		resulting in death)	u.			uence of):				_							
	Examiner		Sequentially list conditions,		sphagi											-		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~			uence of):											
	ficate be executed g physician and ts the burial-transit	xarr	that initiated events resulting in death) Last	U			ar Acci	dent										_
9	be ey	alE			,													
68760	ficate phys s the	edical		d														
Вох	ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	4□Pr	e birth	pf pregna 2 □ Feta time of d	Ideath 3	⊒Ectopic ⊒ Other (s	pregnancy specify) _	y -				23d. Date of Month		ery Day	Year	
P.O.	at the	hys	9 Unknown					1 1 2		!- D-		OSo Did	tabassa	use contribu	ito to t	20.000	of doath?	
Vital Records, I	uires that the de signed by the a Id be detached f	by	Part II. Other significant condi	tions contributing t					cause giv	en in Pa	ırı I.		Yes :				Unkno	
Ö	w require been signature	Completed										24a. Wa		24b. We	re auto	psy findi	ngs availa	ble
Re	he lav e has age 2	dmo										auto perl 1□ Yes	opsy formed? 2⊠N	dea	ıth?	mpletion 2 No	of cause	<b>5</b> †
ta			25. Was case referred to medic	al						26. Pla	ace of Deat	h (Check only		10		20110		_
5	hysician: The la his certificate had I director, page 2	To Be	examiner? 1 ☐ Yes 2ဩ No	Hospital: 1	☐ Inpatie	ent 2 🗆	ER/Outpatie	nt 3 🗆 🖸	OOA Oth	er: 4 🗆	Nursing Ho	ome 5 🖾 Res	sidence	6 □Other	(Specil	(y)		
0	ding Phone. I. After thi funeral		27. Manner of Death	/4	ate of Inju		28b. Time o	of	28c. Injui Wor	ry at		28d. Describe	how inj	ury occurred				
0	tending Pheath. tor: After the	atio	Z L Addident	stigation	ionar, Da,	y ( oui )		M		Yes 2	□No							
Division or	or At fter d Direc in by	Certification:	3 Suicide 6 Coul 4 Homicide dete	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, facto	ory, office			28f. Location City or To			or Run	al Route	Number,			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier  (Check only one)  1 ☑ Certify 2 ☐ Medic	ring Physician: To al Examiner: On th and n	the best e basis o nanner sta	f examina	owledge, deat ation and/or in	h occurre vestigation	ed at the ti on, in my	me, date opinion,	and place, death occur	, and due to the rred at the time	e cause( e, date a	(s) and mann	er as s d due t	tated. o the cau	ıse(s)	
	To th withir To th comp	Me	29b. Signature and title of certi	er		~		2	9c. Licens				29d. D	ate signed (			-	
)	1.5		) som			_	~		D Z	7-7	79			11/2	4/3	200	) /	
	10		30. Name and address of person															
			Susan J. Miller					e, Sui	ite 30	5, Be	thesda	, Maryla	nd 20	0814				
	Sta	te	31. Date filed (Month, Day, Yea	2007	registr	ar's Signa	ature	and the										

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 3:42 A LOEB November 17 CONSTANCE Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 AF 55 Director May 12, 1952 Maryland 220-60-1471 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in the lealth and Mental Hygiene. snt: If item 27 Is marked other than "natural", or Items 23a or: 21703 United States 620 Winter Spice Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Base Administrator Auto Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If item 27 Is marked of any Injury or other traumatic aveonce. ပ Richard L. Herridge Dolores Marie Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronnie Loeb/ Husband 620 Winter Spice Drive, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Inc. 11/24/07 Frederick, Maryland 21. Signature Funeral Service to 22. Name and Address of Facility Stauffer Funeral Home P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Minute **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burlal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 🗆 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Director: in 24 hour.
the Funeral Dire To the

State

Saeed Caidi 2007 Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

Registrar's Signatu

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 Toll House Are Brederick

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

11-20-07

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Marylan	,	artment of Hertificate of D		ental Hygie	ne 2007	39486
ij.	Physici	an.	1. Decedent's Name (First, Middle, Lass	. ,				2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give	Moats	-	4b. City, Town, or I	ocation of Death	11 0	4c. County of Death	1 /4
	Examir	er	12139 Walnut		st	Hagers			Washingt	on
	Funeral Director		5. Social Security Number 217-10-2986 6. Se	x 7. Age (In yrs. I	ast birthday) Yrs.	_	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Young 14)		place (State or Foreign
like.	D ≯		Usual Residence of Decedent  10a. State 10b. County	10c Cip	, Town or Lo	cation				10d. Inside City Limits
	Aaryla f sho	or	MD Washin		ersto					1 □ Yes 2√□ No
	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Exeminar must be notified at	Funeral Director	10e. Street and Number 12139 Walnut Po	oint Rd West		10f. Zip Code 217	40	10g	. Citizen of What Cou	ntry?
	r death	ınera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
21215-0036	ours afte al', or it Exemin		1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No WW I If Yes, Give Year or Dates:	I	1 ☐ Yes 2 🔀 No	Specify:		Specify.whit	e
5-0	72 ho natur	Completed by	15. Decedent's Edi (Specify only highest grad	ucation le completed)	16a. Dece (Give	dent's Usual Occupat kind of work done di DO NOT use retired)	tion uring most of workin	g 16	b. Kind of Business/Ir sand blas	dustry sting
121	within ene.	mpi	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+)		ssemble:		1	nfg.co.	
	2 should be filed within n and Mental Hygiene. Fie marked other than "reumatic event, the Mea	To Be Co	17. Father's Name (First, Middle, Last) Howard Ray Mod				18. Mother's Name Edith G			
Maryland		1-	19a. Informant's Name/Relationship (T	wpe, Print) Wife					ity or Town, State, Zip Hagerst	
Baltimore,	permit. Pages 1 and Department of Heall Important: if Itam 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Dopation 5 □ Other (Specify	CI CI	em <u>etery,</u> crei	sition (Name of natory or other place Jawn Cem.	Nov.	28,	c. Location - City or T Hagerstov	
Balt	permit. Departr Imports any inj		21. Signature of Juneral Service Licens		I I	Name and Address Onald Ed	of Facility Tho	mpson F	uneral H	lome, Inc
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	. Do not ent	er the mode of dying	such as cardiac or	respiratory arrest	ig, MD 21	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Met	25/21	c Mel	chone			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ						
15	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ience of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ience of):					
8760,	ate be ex nysician he buria	calE		d						
Õ	rtificate ng phys as the	Jedi	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed ate been signed by the eltending physician and page 2 should ba detached for use as the burial-transit	Physician/Medicai	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	es that I igned by ba deta	ьу Р	Part II. Other significent conditions co	ntributing to death but not resu	ilting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to t	
ord	w require been sig should t						-	1 🗆 Yes	2ØNo 3☐Pro	oably 4 □Unknown
Vital Records,	The law re cate has be page 2 sho	Completed						24a. Was an autopsy performe	d? prior to co	opsy findings available impletion of cause of
ita	ician:   certifica rector, p	Be C	25. Was case referred to medical examiner?				26. Place of Death		,,,,,	
of V	Physician: r this certifica ral director, <sub>I</sub>	ဥ	1 ☐ Yes 2 ☑ No		ER/Outpatier		4   Nursing Horr		e 6 Other (Speci	(y)
ion	Attending P r death. sctor: After I by the funers	ation:	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	at ? es 2 □No	8d. Describe how	injury occurred	
Division	tei or Atte s aftar de ni Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medicai (		sicien: To the best of my knowiner: On the basis of examinat and manner stated.						
	To the within 2 To the comple	Σ	29b. Signature and title of certifier  Muhael	J. Mulow	1 m	29c. License	number	290	Date signed (Month,	Day, Year)
54	15+1		30. Name and address of person who c	1. Charale	23a) (Type,			mes	1de jeret	eun Ma
	Sta Registr		31. Date tiled (Month, Day, Year)	32. Registrar's Signa	. /	1			J. V + 1	
DH	MH 17 Rev 1/2	V-		Belgion !	1 1 mg	300 Sel				

DHMH 17 Rev 1/2001

ORIGINAL

_			1 - For State Registrar	State of Ma	aryland / i	Departmo <i>Certific</i>	ent of H	lealth and N Death		giene 0	07	39487
			1. Decedent's Name (First, Middle, I	_ast)			-		2. Date of De		Vana	3. Time of Death
	Physici /Medio Examir	cal	WILLIAM  4a. Facility Name (If not institution, g	RICHARD		McCAUL 4b. C		r Location of Death	NOV Month		Year 2007 y of Death	4:55 P M
	LAGIIII	ıçı	ATLANTIC GENER				BER				RCEST	rer
	Funeral	-		Sex 7. Age	e (In yrs. last bii		der 1 Year		8. Date of Bir		9. Birtho	place (State or Foreign
	Director		220-22-6497	1 X M 2 □ F	78	Yrs. Mont	hs Days	Hours Min.	8. Date of Bir (Month, Da DEC 15	, 1928	MAI	RYLAND
	pu ,		Usual Residence of Decedent		10 01 7							
	aryla ehov	_	10a. State 10b. County		10c. City, Tow						1	10d, Inside City Limits 1 ☐ Yes 2 🛣 No
	8a-f	Director	DELAWARE SUSSI	EX	SE	LBYVILI						
	with t	吉	10e. Street and Number			10f.	Zip Code			10g. Citizen of		ntry?
	• 23g	<u>ea</u>	37666 RIVER RU			10.111	1997			US		
	iten de	Funeral	11. Marital Status 1 □ Never Married 2 1 Married	12. Was Decedent 8 Armed Forces? 1 X Yes 2 □ N		If Yes, s	specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	- I4. Hai	ce - Amendick, White,	can Indian, etc.
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Ye	s 2 No	Specify:		Specia	<sup>fy:</sup> WH]	LTE
ŏ	n 72 hours after death with the Marylan "natural", or Iteme 23a or 28a-f ehow edical Examinal transite multiled at	ted	15. Decedent's	Education		. Decedent's L	Isual Occup	ation		16b. Kind of B	Business/In	dustry
215	within 72 hours after death with the Maryland ane. than "natural", or iteme 23e or 28e-f ehow the Madical Examinar mast be mulling at	ple	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	5+)	(Give kind of life. DO NO	work done of Tuse retired	during most of work ()	ing			
2	e filed within al Hygiene. other then '	Completed	8			DE	CORAT	OR		INTE	RIOR	DESIGN
7 5	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La.					18. Mother's Name				
008   17 15  1928 limore, Maryland 21215-0036	s 1 and 2 should be filed within f Heelth and Mental Hygiene. Item 27 is marked other than other traumatic event, It.e M.	၉	WILLIAM	RAYMOND	McCAI	JLEY		VIRGIN	IIA ————	MARIE	JAN	1ES
15/War	12 sh hand ris n	. 8	19a. Informant's Name/Relationship					and Number or Run				) Code)
(2)	Heelth Heelth tem 27		JOHANNA E. McCAU  20a. Method of Disposition	TEX/MTLE	-	666 KL		UN, SELBY	VILLLE,	DE. 199 20c. Location		Ctata
8 20	ages nt of l		1 ☐ Burial 2 🖾 Cremation 3		cemete	ry, crematory o	or other plac	e)				
$\begin{cases} \log \beta \\ \text{Baltimore,} \end{cases}$	it. Partime		4 □ Donation 5 □ Other (Special Signature of Funeral Signature of		CREMAT			ARVA 11/2 ss of Facility	1/07	DELMAR	, DEI	LAWARE
Ba	permit. Pages 1 and Department of Heelt Important: If Item 2 eny injury or other ODCs.			111				UNERAL HO	ME SET	RYVILLE	175	19975
9			23a. Enter the dise se, or co	m lications that cause	the death. Do						, DE	Approximate
	Physician		Immediate Cause (Final	y one cause on each lin	10.							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence	OKE	•				-	
9	Examiner					,-						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence	of):						
3	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
. 09	cate be executed obysicien and the burial-transit	Ĕ	resulting in death) cast	Due to (or as a	a consequence	of):						
75°	certificate be Iding physicie Ise as the bur	dical		d								
× 6.	leath certifica ettending ph I for use as th	/We	IF FEMALE:	23c. If yes, outcome	of pregnancy					224 Da		
>-8	etter for u	clar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death	3 ☐Ectopia 5 ☐ Other	c pregnancy (specify)				ate of delive onth	өгу Day Year
MO	t the d by the tached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	- 72		(-1//					
MCCAUL Records, P	Attending Physician: The law requires that the death redeath. r death. ector: Atter this certificate has been signed by the etter by the funeral director, paus 2 should be detached for u	by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in	n the underlyin	g cause give	en in Part I.	23e. Did to	obacco use con	tribute to th	he cause of death?
TA Sprage	v require been sig should t	bed							10	res 2□No	3 🗌 Prot	pably 4 Dunknown
77	e lawre has be	plet							24a. Was			ppsy findings available
VILLIAM MC(A)	certificate harector, page	Completed							perfo	rmad?	death?	mpletion of cause of 2 ☐ No
/ita	certificate	Be (	25. Was case referred to medical examiner?		-			26. Place of Death				
Z 1	Physic this c	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatier		tpatient 3		4 🗆 Nursing Ho	me 5 Resid	tence 6 □Ott	ner (Specif	ý)
₩, no	ding P. After funera	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. 1	Time of njury	28c. Injury Work		28d. Describe t	now injury occur	rred	
isic	death death stor: /	cat	2 Accident investigati 3 Suicide 6 Could not	be Co. Diana dia	415	М		Yes 2 □No	006 1 1	2		
V/V	after Direct	Certification:	4 ☐ Hornicide determine	d 28e. Place of Inju building, etc	c. (Specify)	ırm, street, iac	tory, onice		City or Tox		per or Hura	al Route Number,
.>	Spita hours inerei	a C	29a. Certifier 1 Certifying F	Physician: To the best of	of my knowledge	e, death occurr	ed at the tim	ne, date and place,	and due to the	cause(s) and m	anner as s	tated.
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Ext	aminer: On the basis of and manner sta	examination an	d/or investigat	ion, in my op	oinion, death occurr	red at the time,	date and place,	and due to	o the cause(s)
	Tot Com	Σ	29b. Signature and little of certifier	M-D			29c. License	number		29d. Date signe	ed (Month,	Day, Year)
	NVK		14111	,			000	09120		11/20	107.	
	u fy	- [	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print)	drive	Berlin	MI	2/3	11	
	Sta		Zees han, Htif 31. Date filed (Month, Day, Year)								•	
	Registra		NOV 2 6	2007	ar's Signature	Coc	de)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 39488 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Freda Mary Miller November 26, 2007 11:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 29316 Will Street Talbot Easton 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Kentucky 1 □ M 2 🖾 F 69 406-54-2984 November 29, 1937 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 □Xes 2 □ No Kentucky Lincoln Stanford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 885 Goshen Road Lot 10 40484 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 HNo Specify: Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) X-Ray Technician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillips Dellie Green Ellen Hale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Eaton 29316 Will Street, Easton, Maryland Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 ☑ Removal from State 12/1/2007 4 Donation 5 Dother (Specify) Highland, Kentucky Fairview Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. Jando 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Moar Denton, Maryland 21629 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATORENAL SYNDROME DAYS Due to (or as a consequence of): CIRRHOSTS YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NON-ALCHOHOLIC STEATOHEPATITIS Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSRTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 **Exertifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

burial-transit be executed Box 68760 attending physician the for use P.O. ed by the a detached f Records, page 2 s certificate or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Division

Examiner Physician/Medical ð Completed Be 2 Medical Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

ō pe 23a must

7 is marked other than "natural", or items traumatic event, the Medical Examiner mu

I Hygiene.

is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked oth any Injury or other traumatic event

Physician

/Medical

Examiner

Funeral Director

þ

Completed

Be

ဥ

death with the Maryland

Maryland 21215-0036

saltimore,

State Registrar

(Check only one)

29b. Signature and title of certifier

29c. License number DO

29d. Date signed (Month, Day, Year)

NOVEMBER 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 219 32. Registrar's Signature 219 South Washington Street, Easton, Maryland 21601 Lakshmi Vaidyanathan, 31. Date filed (Month, Day,



ORIGINAL

			1 - For State Registrer	State of Marylan		artmen rtificat			and Me		iene .g. N2 0 0 7	39489
I	Physici	an	1. Decedent's Name (First, Middle, Last) Charlotte Patric	is Ningard	Morr	ic			N	2. Date of Deat	h Day 2 20	3. Time of Death 2:30 A M
	/Medic		4a. Facility Name (If not institution, give str		MOTI		Town or	Location o		10 veinbe	4c. County of De	
	Examin	er	6710 Carpenter R					rick			Freder	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) 63 Yrs.		1 Year Days		Min	8. Date of Birth (Month, Day, Iar. 15,	0.5	Birthplace (State or Foreign Country) ryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Maryli f sho	jo	Maryland Frederic	rk Fr	ederio	- k						1 □ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number			10f. Zip	Code			1	0g. Citizen of What	Country?
	23a c		6710 Carpenter Road	i			1702				United S	
	er de:	Funeral	Tr. Maria States	2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spec i, Puerto P	cify Yes or No- lican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
36	urs aft	þ	1 ☐ Never Married 2 反 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No 196 If Yes, Give Year or Dates: 19	967	1 🗌 Yes	2 <b>☑</b> No	Specify:			Specify: W	nite
2	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show ha Madical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	16a. Dece	kind of wo	rk done o	turina most	t of workin		16b. Kind of Busine	ss/Industry
12	Mithin then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired,	)			O II	
Q 7	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		Homen	naker		18. Mothe	r's Name	(First, Middle, M	Own Hon Maiden Sumame)	ne
au	lid be fental rked c	To Be	Winfield Frederick	Ningard				Mary	Char	lotte H	Holly	
Maryland 21215-0036	2 should have had he man	0	19a. Informant's Name/Relationship (Type			-					City or Town, State	
≥ ``	and the lith im 27		Max Morris / Husbar		0/10 Place of Dispo						t, MD 2170 20c. Location - City	
nor	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene.  Depertment of Heelih and Mental Hygiene.  Important: if item 27 is marked other than "natural; or liems 23a or 28a-f ahow any finury or other traumatic event, the Macical Examiner must be notified as once.		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Re	moval from State	emetery, crer Res	thave	ther place N		lov.	26,		
Baltimore,	nit. Portme		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses		emoria				20 <sup>y</sup> 1 C-		Skkot Co	, Maryland
ä	Depermine Depermine Important Important Information In		1/1/								derick, N	
			23a. Part1. Enter the disease, or implication shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not ent	ter the mod	le of dying	g, such as	cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical	6 0	Immediate Cause (Final disease or condition resulting in death)	Graft versus		Disea	ase					
	Examiner			Due to (or as a conseq								
		Jer	Saquentially list conditions, if any, leading to immediate cause. Enter Underlying	Acute Myeloi	uence oi):	cemila						
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Thrombocytop								
760,	te be executed ysicien and te burial-transit	cai Ex	resolving in Godally Cast	Due to (or as a conseq	uence or):							
687	ficate phys		d.									-
	death certifica e ettending ph id for use as th	M/us	23b. was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic p	reonancy				23d. Date of	
.O. Box	res that the death certificate be executed igned by the ettending physicien and be deteched for use as the burial-transit	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant at time of d		Other (sp					Month	Day Year
<u> </u>	The law requires that the te has been signed by thosage 2 should be deteched.	y Ph	Part II. Other significant conditions conti	ibuting to death but not res	ulting in the u	inderlying o	ause give	en in Part I.		23e. Did tob	pacco use contribute	to the cause of death?
rds	w requires been sign should be									1 □ Y€	es 2½₹No 3□	Probably 4 Unknown
ဝင္ပ	e lawre has bee je 2 sho	Completed								24a. Was a		autopsy findings available to completion of cause of
œ =		Соп								perform	ned? death 2XXNo 1 ☐ Y	
Z Z	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	spital:			Othe	25		Check only on	7.	
ō	ding Phys h. After this funeral di	. To	1 ☐ Yes 25XNo  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		28c. Injury Work	4 🗆 140			ence 6 □Other (S ow injury occurred	pecify)
<u>o</u>	Attending Physician: r death. ector: After this certific by the funeral director,	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		<br Yes 2 🗆 !	No			
Division of Vital Records,		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)	reet, factor	y, office		2	8f. Location (St City or Town		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier 1 Certifying Physic (Check only one)	cien: To the best of my known: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	id place, a ith occurre	nd due to the cand at the time, d	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29	c. License	e number		2	9d. Date signed (Mo	onth, Dey, Year)
ì	in		> Through a	The MO	>	1	000	366	10		11-24	-2007
5	TIVA		30. Name and address of person who com								,	
			Edward Fisher, M.D.  31. Date filed (Month, Day, Year)			4		erick	, MD	21702		
	Sta Registr		NOV 2 6 200	32 Registrar's Signa	J 40	rade						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39490 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 /Medical CHAUNCEY MASON FRIEND , SR 26 1330 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY Birthplace (State or Foreign Country) Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, 5. Social Security Number **Funeral** Davs Hours Min. 1. M 2 □ F 103 Feb 6, 1904 Maryland Director 220-16-6520 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 X Yes 2 □ No Friendsville MD Garrett Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 21531 USA 1134 Sawmill Lane by Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. white Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Garrett County Board Elementary/Secondary (0-12) College (1-4or 5+) of Education 4 yrs. School Teacher of the state of th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Ethel Minerva Kelley Sherman Friend 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1134 Sawmill Lane, Friendsville, MD Betty Lou Humberson/daughter Health a or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or Nov 30, 2007 Friendsville, MD Blooming Rose Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., P.O. Box 275 0 Grantsville, MD 179 Miller St., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIV one day Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** BSTRUCTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 🔀 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an s certificate has b lirector, page 2 s autopsy performed? Yes 22No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2
▼ No 2 ER/Outpatient 3 DOA 2 1 Tyes 1XInpatient this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Jabahat

31. Date filed (Month, Day, Year)

Box

Grantsville, Maryland 21536

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

2007

m

10 32. Registrar's Signature

WAWHO

8

2 NOA

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Day $\mathbf{P}^{\mathsf{M}}$ 20 9:50 SAMUEL C. T. McDOWELL NOV 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 234-14-0312 87 MAR 14 1920 WV Usual Residence of Decedent 10c. City, Town or Location 10d. Inside, City Limits 10b. County 1 Yes 2 □ No MONTGOMERY GAITHERSBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9312 EDGEWOOD DRIVE 20877 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Wyes 2□No 1943— If Yes, Give Year or Dates:1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DEPT. OF ENERGY SCIENTIST 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SAMUEL WILLIAM McDOWELL GWENYL DAVIES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY SMITH / DAUGHTER P.O. BOX 337, BARNESVILLE, MD 20838 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State STAUFFER CREMATORY 11/24/07 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOXIA AND HYPOTENSION 60 mins disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE 1 day Due to (or as a consequence of): ASPIRATION PNEUMONIA 3 days Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown

**Physician** /Medical Examiner

and

physician a s the burial-

page

certificate

Director:

hours after within 24 hours at To the Funeral C completely filled i

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

Items 23a or 28a-f show ner must be notified at

ō

"natural"

al Hygiene. I other than " event, the Me

is marked

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Director

Funeral

Completed by

Be

2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

and Mental

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Physician/Medical þ Completed Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perfor 1□ Yes

1 Tyes

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 No 3 Probably 4 Unknown

27. Manner of Death 1 Natural 2 ☐ Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

(Check only one)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

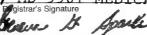
29b. Signature and title of certifier 10 xender 29c. License number D0065819 29d. Date signed (Month, Day, Year) NOV. 20, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALEXANDER MULAMULA, MD 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD

State Registrar

Medical



# g ( To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

,	For State Registrar		State o	f Marylan			of Health <i>of Deat</i>			giene Reg. No:		201.02
cian	Decedent's Name     MTLDRED	(First, Middle, Las	NTEL	D					2. Date of De Month NOVEMBE	ath Day	Year	3: Time of Death
iical iner	4a. Facility Name (If REEDERS I	not institution, give MEMORIAL	e street and nur HOME					on of Death	)	4c.	County of Death WASHIN	
ıl r	5. Social Security Nu 219-20-3	514 1	ex □M 2 <b>∑</b> F	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Months	Year If Und Days Hours	ler 24 Hrs. s Min.	8. Date of Bir (Month, Da FEB. 2	y, Year)	Cou	place (State or Foreign ntry) ARYLAND
tor	Usual Residence of I  10a. State  MARYLAND	10b. County WASHII	NGTON	10c. City	y, Town or Lo		BOONSBO	ORO				10d. Inside City Limits 1   Yes 2   No
al Director	10e. Street and Num	ber				10f. Zip C				10g. Citi	zen of What Cou	•
by Funeral	11. Marital Status  1 Never Marrie 3 Widowed		12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or D	2⊠No ∕e		Was Decede If Yes, specif 1 ☐ Yes 2			ecify Yes or No Ricen, etc.)		14. Race - Ameri Black, White Specify: WH	
Completed	(Special (Sp	15. Decedent's Edity only highest grandary (0-12)	ducation ide completed) College (1	I-4or 5+)	(Give	<i>DO NOT u</i> se	done during m retired)	nost of work	ing		nd of Business/Ir	ndustry  MANUFACTUR
To Be Completed by	11 17. Father's Name (# CHARLES		)			CL		other's Name	)DS			MANUFACIUR
	19a. Informant's Nat	A. HOUGH			11 B	EDROCK	LANE,	KEEDY	SVILLE	, MAI		21756
		Cremation 3 5 Other (Specif	2	State		matory or oth N MEM	PARK Address of Fa	12/0		HAG		MARYLAND
	23a, Part1, Enter th	e disease or com	Par Par	ul M. De	ean B	AST FU	NERAL I	HOME	Boonsb	oro,	ational <u>Maryla</u> n	d 21713 Approximate
	Immediate Cause (F disease or condition resulting in death)		a. Due to	yorv (ords a consequence of Van C	ed	Den	etca ele	,				Interval Between Onset and Death 3 - 0 1/w.
dical Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or in that initieted events resulting in death) Landau (Cause (Disease or in the cause) (Diseas	mediate lying njury ast	c. C	(or as a consequence of the structure) (or as a consequence of the structure)	len	1) Bb	cle (	Colili	5			1-2049.
Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 ☑ 9 □ Unknown	months?	1□Live b	tcome pf pregna birth 2 ☐ Feta nant at time of d own	ildeath 3[	⊒Ectopic pre ⊒ Other (spe					23d. Date of deliv	very Day Year
by	Part II. Other signifi	cant conditions	contributing to d	eath but not res	ulting in the u	nderlying cau	use given in Pa	art I.			use contribute to ☐ No 3 ☐ Pro	the cause of death?
Completed									24a. Was auto perfo		prior to c death?	opsy findings available ompletion of cause of 2 ☐ No
To Be (	25. Was case referrence examiner?	No	L		ER/Outpatie		Other: 4	Nursing Ho		dence	6 □Other (Spec	ify)
Certification:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide	5 Pending investigation 6 Could not be determined	e 28e. Place	th, Day Year) of injury - At hoing, etc. (Specif	28b. Time of Injury	M	c. Injury at Work? 1 Yes 2	No	28f. Location ( City or To	Street an	nd Number or Ru	ral Route Number,
ledical Cer	(Check only	1 <mark>⊅</mark> Certifying Ph 2   Medical Exa	miner: On the b	asis of examina								
Med	29b. Signature and t	title of certifier	and man	ner stated.		29c.	License numb	er (-,		29d. Da	te signed (Month	, Day, Year) 8 , 2007
state strar	30. Name and addre	ALA OADT	R. 2031	1 LAPPA gistrar's Signa	NS ROA		NSBORO	, MAR	/LAND 2	1713	301-43	8 , 200 82-8470

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Name		Registrer			Ce	rtificate of	Death		Reg. No.	.00	, 0	149
		1. Decedent's Name (First, Middle, I	Last)					2. Date of D Month	eath Day	Ve	3. Tir	ne of Death
Physici Medic/		DARIO	Α.	PAGLI	ΑI			NOVEMB			7 10	:01 A
/Medic Examin		4a. Facility Name (If not institution, g	give street and nun	nber)		4b. City, Town,	or Location of D	eath	4c.	County of [	Death	
		10606 Dunkirk D	Orive			Silver	Spring		Mo	ntgor	nerv	
uneral			. Sex	7. Age (In yrs. la	ast birthday)		r   ff Under 24 l	Hrs. 8. Date of B	irth		Birthplace (St Country)	ate or Fore
irector		484-01-2937	1 M 2 □ F	88	Yrs.	Months	5 Hours IV	Feb. 2	8, 19	919	Iowa	
		Usuaf Residence of Decedent									404 5-4	to Oh at the
how a	_	10a. State 10b. County			r, Town or Lo							de City Lin Ves 2□
9	Director	Maryland Montgom	nery	Si	lver	Spring						Yes 2 <del>V</del>
important: if item 27 is marked other then "natural", or iteme 23s or 28s-1 show eny injury or other treumatic event, the Medical Examinar must be notified at once.	Jire	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of Wha	t Country?	
23a	a	10606 Dunkirk I	Orive			2	0902			USA		
£ 5	by Funeral	11. Marital Status	12. Was Dece Amed For	dent Ever in U.S	S. 13.	Was Decedent of	Hispanic Origin	(Specify Yes or Nuerto Rican, etc.)	0- 1		American fndia White, etc.	n,
9 cr	F	1 Never Married 2 Married		2 🗆 No		1 ☐ Yes 2 🛣 N		,				
Exe.	d b	3 XWidowed 4 □ Divorced	Year or Da	ates:WW II						Specify: V		
disa	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual Occ kind of work don	e during most of	working	16b. Kir	nd of Busin	ess/Industry	
4	ldu	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retir	red)					
	CO		4		Acco	untant			_		l Manag	emen
D O O	Be	17. Father's Name (First, Middle, La	st)				18. Mothers	Name (First, Middle	e, Maiden	Sumame)		
atic	2	Giuseppe Pac	qliai					osina Bar				
E E		19a, Informant's Name/Relationship						Rurai Route Numi				
n 27 ier tr		Carla McGarry /	Daughte				Lane, I	Rockville	·			
r of t		20a. Method of Disposition 1 Burial 2 Cremation 3	□ Removat from S	C-0	lace of Dispo emetery, cre	osition (Name of matory or other p	ace)	Date	20c. Lo	cation - Cit	y or Town, Sta	te
		4 □Donation 5 □ Other (Special		Gat		Heaven		7. 26, 20				
in in		21. Signature of Funeral Service Lic	censee		2:	2. Name and Add	ress of Facility F	rancis J lvd., wes	. Col	lins	Funera	1 Ho
E . 9		Many &	Day 1		1	Silver S			L			
		disease or condition resulting in death)	Due to (	or as a consequ	ience of):						Offset	
edical miner	I Examiner		b. Due to (c		rence of): PERY D uence of):						Onset	
ettending physicien and cor use as the burial-transit	cal	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (c CORON  Due to (c  Due to (c  d.  23c. If yes, outc	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of de	uence of):  Jence of):  Jence of):  Jence of):  Jence of):		су		2	23d. Date o Month		Year
ettending physicien and incoming physicien and incoming transit incoming transit incoming the physicien and physicien and physicien and physicien and physicien and physicien and physi	cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (control of the control of th	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of depond	pence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):	□Ectopic pregnar		23a, Did		Month	f defivery Day	Year
eltending physicien and in the for use as the burial-transit in	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (control of the control of th	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of depond	pence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):	□Ectopic pregnar			tobacco u	Month se contribu	f defivery Day	Year
ettending physicien and for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (control of the control of th	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of depond	pence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):	□Ectopic pregnar				Month se contribu	f defivery Day	Year
Is been signed by the ettending physicien and 2 should be deteched for use as the burial-transit 0	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (control of the control of th	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of depond	pence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):  Dence of):	□Ectopic pregnar		1	tobacco u	Month se contribu No 3[ 24b. Wer	f defivery Day  te to the cause Probably  re autopsy find r to completion	Year e of death 4 <b>X</b> Unkr ings avai
as been signed by the ettending physicien and 2 should be deteched for use as the burial-transit 0	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (control of the control of th	or as a consequence or as a consequence of pregnar irth 2 Fetal ant at time of depond	pence of):  Dence of):	□Ectopic pregnar		24a. Wa aut	tobacco u	Month se contribu No 3[ 24b. Wer	f defivery Day  te to the cause Probably  re autopsy find r to completion	Year of death AUnkn
ss been signed by the eltending physicien and 2 should be deteched for use as the burial-transit 0	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (control of the control of th	or as a consequence or as a consequence of pregnar irth 2 □ Fetal ant at time of depond	pence of):  Dence of):	□Ectopic pregnar □ Other (specify) underlying cause of	given in Part I.	24a. Wa aut	tobacco u  Yes 2 [ s an opsy formed? 2 X No	Month se contribu No 3[ 24b. Wer	f defivery Day  te to the cause Probably  re autopsy find r to completion th?	Year of death AUnkn
ss been signed by the effending physicien and 2 should be deteched for use as the burial-transit 0	Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part If, Other significant conditions  AORTIC ANEURYS	Due to (capable of the capable of th	or as a consequence or as a consequence of pregnarith 2 Fetal and at time of deciven	pence of):  PERY D  Pence of):  Pence of of):  Pence o	□Ectopic pregnar □ Other (specify) underfying cause of	26. Place of	24a. Wa auto peri 1 Yes	tobacco unity yes 2 [ s an opsy formed? 2 X No	Month se contribu No 3[ 24b. Wer prio. dear	f defivery Day  te to the cause Probably  re autopsy find r to completior th? Yes 2[_XNo	Year of death AUnkn
as been signed by the ettending physicien and 2 should be deteched for use as the burial-transit 0	To Be Completed by Physician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part If. Other significant conditions  AORTIC ANEURYS  25. Was case referred to medical examiner? 1 □ Yes 2 ⋈ No  27. Manner of Death	Due to (c CORON  Due to (c  Due to (c  d.  23c. If yes, oute 1   Live bi 4   Pregna 9   Unkno  contributing to de  SM  Hospitaf: 1   Ir  28a. Date of	or as a consequence or as a consequence of pregnar and at time of december of the consequence of the consequ	rence of): rence of):	□Ectopic pregnar □ Other (specify) underlying cause o	26. Place of there:	24a. Wa autoped	tobacco u  Yes 2  s an opsy formed? 2  No one)	Month se contribution of the contribution of t	f defivery Day  te to the cause Probably  re autopsy find r to completior th? Yes 2[_XNo	Year of death AUnkn
as been signed by the ettending physicien and 2 should be deteched for use as the burial-transit 0	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (c CORON  Due to (c  Due to (c  Due to (c  Due to (c  d.  23c. If yes, out 1   Live bi 4   Pregni 9   Unkno  s contributing to de  SM  Hospitaf: 1   Ir 28a. Date c (Monti	or as a consequence or as a consequence of pregnar and at time of december of the consequence of pregnar and at time of december of the consequence of pregnar at time of december of the consequence of th	rence of):  PERY D  Rence of):	□Ectopic pregnar □ Other (specify)  underfying cause of the control of the contr	26. Place of ther:  4   Nursinury at ork?  1 Yes 2   No	24a. Wa autuped 1 Yes Death (Check only 28d. Describe 28d. Location	tobacco u  Yes 2 [ s an oppsy tormed? 2 [ a No one) sidence 6 to how injury	Month se contribu No 3[ 24b. Wer prior dea 1   5   Other (y occurred	f defivery Day  te to the cause Probably  re autopsy find r to completior th? Yes 2[_XNo	Year of death  Munkm  Ings avail
Tuneral Director; After this certificate has been signed by the etlanding physicien and sely filled in by the funeral director, page 2 should be deteched for use as the burial-transit of	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown  Part If. Other significant conditions  AORTIC ANEURYS  25. Was case referred to medical examiner? 1   Yes   2   No  27. Manner of Death 1   Natural   5   Pending investigat   2   Accident   3   Suicide   6   Could not determine   29a. Certifier	Due to (c CORON  Due to (c C. Due to (c d. D	or as a consequence or as a consequence of pregnarith 2 Fetal and at time of department 2 for finjury	rence of):  PERY D  Lence of):	DISEASE    Ectopic pregnar   Other (specify)	26. Place of ther:  4 Nursin ury at ork?  Yes 2 No	24a. Wa autuped 1 Yes Death (Check only 28d. Describe 28d. Location	tobacco u  Yes 2 [ s an opsy formed? 2 [ No one) sidence 6 how injury  (Street and own, State) e cause(s)	Month se contribution of the second of the s	f defivery Day  te to the cause Probably re autopsy find r to completior th? Yes 2 (**INC)  Specify)  or Rural Route er as stated.	Year of death deat
uneral Director; After this certificate has been signed by the ettending phystolen and siy filled in by the funeral director, page 2 should be deteched for use as the burial-transit of	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (c CORON b. Due to (c CORON d. Due to (c d. Due to	or as a consequence or as a consequence of pregnarith 2 Fetal and at time of department 2 for finjury	rence of):  PERY D  Lence of):	DECtopic pregnar Other (specify)  Int 3 DOA Control 28c. In W. M. 11  Interest, factory, office th occurred at the investigation, in my	26. Place of ther:  4 Nursin ury at ork?  Yes 2 No	24a. Wa autroper 1 To Yes  Death (Check only ig Home	tobacco u  Yes 2 [ s an opsy formed? 2 [ No one) sidence 6 how injury (Street and wn, State) e cause(s) , date and	Month se contribu No 3[  24b. Wer prio dea 1     5   Other (y occurred downward) and manne place, and	f defivery Day  te to the cause Probably re autopsy find r to completior th? Yes 2 (**INC)  Specify)  or Rural Route er as stated.	Year a of death 4 AUnkn ings avail 1 of cause
To the Funeral Director; After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriat-transit of	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part If. Other significant conditions  AORTIC ANEURYS  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural   5   Pending investigat   3   Suicide   4   Homicide   4   Could not determine (Check only one)	Due to (c CORON b. Due to (c CORON d. Due to (c d. Due to	or as a consequence or as a consequence of pregnarith 2 Fetal and at time of department 2 for finjury	rence of):  PERY D  Lence of):	DISEASE    Ectopic pregnar   Other (specify)	26. Place of ther: 4 Nursin ury at ork? Yes 2 No	24a. Wa auture per 1	tobacco u  Yes 2 [ s an oppsy formed? 2 [ No one)  sidence 6 how injury  (Street and own, State)  e cause(s) , date and	Month se contribution of the contribution of t	f defivery Day  te to the cause Probably  e autopsy find f to completion fyes 2 (XNo Specify)  or Rural Route er as stated. due to the cause	of death  Munknings availation cause  Number,  use(s)
been signed by the ettending physicien and should be deteched for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part If. Other significant conditions  AORTIC ANEURYS  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural   5   Pending investigat   3   Suicide   4   Homicide   4   Could not determine (Check only one)	Due to (c CORON b. Due to (c CORON d. Due to (c d. Due to	or as a consequence of pregnarith 2 Fetal and at time of debum at the but not result of fnjury h, Day Year)  of Injury - At horng, etc. (Specify, best of my knows as a consequence of pregnarith 2 Fetal and at time of debum at time of debum at time of debum at time of debum and time of debum at time of debum at time of debum at time of the pregnant at time of the p	rence of):  PERY D  Rence of):	DISEASE     Ectopic pregnar    Other (specify)	26. Place of ther: 4 Nursin ury at ork? Yes 2 No e time, date and pir opinion, death of the need not be the need to the need t	24a. Wa auture per 1	tobacco u  Yes 2 [ s an oppsy formed? 2 [ No one)  sidence 6 how injury  (Street and own, State)  e cause(s) , date and	Month se contribution of the contribution of t	re autopsy find r to completion th?  Yes 2 No.  Specify)  Probably  Yes 2 No.  Specify)	Year of death death lings avail of cause  Number, use(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:05 P M 18, 2007 Virginia Ouigley Louisa November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 685 Old Colony Cove Road Friendship If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-21-1912 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F Yrs. Wash., D.C. 578-01-6658 95 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location "natural", or Items 23a or 28a-f show adio I Examiner must be notified at 1 ☐Yes 2 No Director Friendship MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with a nand Mental Hygiene. Is marked other than "natural", or Items 23a or 3 **USA** 20758 685 Old Colony Cove Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 🔀 No 3altimore, Maryland 21215-0036 Specify Specify: white Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agriculture tobacco farmer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Cunningham Compton James Burrell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other tra 1120 20th St., N.W., Washington, D.C. 20036-3437 Arthur C. Elgin, Jr., attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-27-2007 | Wash., D.C. 4 □ Donation 5 □ Other (Specify) Oak Hill Cemetery 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Euneral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2-3 month Physician /Medical Due to (or as a consequence of) Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed use as the burlal-trar Due to (or as a consequence of) Box 68760, attending physician for use as the burla IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 20 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed death? 1 ☐ Yes 2 ☐ No 2 1□ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 No 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö

24 hours after death Funeral Director: filled in by Hospital completely hin 2

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10845 Town Center Blvd., Suite 203, Dunkirk, MD 20754 Catherine Brophy, M.D.,

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

32. Registra Signature 31. Date filed (Month, Day, Year) NOV 2 2007

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:00 pM November 17, 2007 Haydee Aguilar Rivera /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care of Silver Spring Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 03/22/1925 231-82-5025 82 Nicaragua Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 1 ☐ Yes 2 NO Director Howard Columbia Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 21044 U.S.A. 10799 Hickory Ridge Road, #12 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1⊠Yes 2□No Specify: Specify δ 3 ☑ Widowed 4 ☐ Divorced White Nicaraguan "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Tailor Garment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aminta Perez Arturo Aguilar ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10019 Rolling River Run, Laurel, Maryland 20723 Caroline Wright-Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other pla Maryland National Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/2007 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, 21. Signature of Fuperal Service Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardio-Respiratory Arrest resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed Exami burial-trar and Due to (or as a consequence of): attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Year Day in the past 12 months? 1 ☐ Yes 2 ☒ No the 9 Unknown É Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 5 Pendina

Division or Vital Records, P.O. Box 68760 s after death. the Hospital or

Baltimore, Maryland 21215-0036

1 🙀 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

Medical

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

November 19, 2007 D0055362

2101 East Jefferson Street, Rockville, MD 20852 Irina Selya, M.D., 31. Date filed (Month, Day, Year) NOV 2 6 2007

State Registrar



To the Hospital of within 24 hours at To the Funeral Completely filled in

			Please	Type or Prin								_egible.		
			For State	State of Ma	ıryland		•			Mental Hy	giene			
И,			Registrar  1. Decedent's Name (First, Middle, L	ast)			Certific	ate or	Deatti	2. Date of D	Reg. No.	2007	3.47ime	of Death
	Physicia		I-EON HE	RRFRI	Ri	$\subset E$	_			Month	Day	Year	20 1	AM
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	1/1			ity, Town, c	or Location of Dear	th		County of Death		
	-Admin	<b>-</b> '	Calvert M	lemorial Hospital				F	rince Freder				lvert	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age	(In yrs. las		Mont	der 1 Year hs Days	If Under 24 Hrs Hours Min		rth ay, Year)	9. Birth Con	place (Stat Intry)	e o <i>r Foreign</i>
k	Director		217-42-4450 Usual Residence of Decedent		63	Yrs	·.			Nov	9, 1944		MD	
	land ow at		10a. State 10b. County		10c. City,	Town o	r Location						10d. Inside	City Limits
	Many 1-f sh ffied	ţò	MD (	Calvert					Sunderlan	d			1 🗆 Y	es 2 No
	or 28g	Director	10e. Street and Number				10f.	Zip Code			10g. Citiz	en of What Co		
	23a ust b	ral	4985 Sunny Hills Drive						20689			U.S.		
	tems ter m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?			13. Was De	cedent of F specify Cub	Hispanic Origin? (S ean, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0- 1	<ol> <li>Race - Amer Black, White</li> </ol>		
0000	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	10		1 ☐ Yes	s 2 XNo	Specify:			Specify: Bla	ck	
3	2 hou		15. Decedent's	Education		16a. De	ecedent's L	Isual Occup	pation		16b. Kin	nd of Business/I	ndustry	
2	hin 7. e. an "n Medi	ple	(Specify only highest g	rade completed)  College (1-4or 5-	+)	(C	fe. DO NO	work gone Tuse retire	during most of wo	orking				
V	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	9						Owner	(Fire to the first of the		andscaping	Compa	any
and	be fill ad oth even	Be	17. Father's Name (First, Middle, La.		D:				18. Mothers Na	me (First, Middle	e, maiden s Iuanita			
Ž	d Mer d Mer marke matic	욘	19a. Informant's Name/Relationship	Herbert Leon I	Rice	19h M	lailing Addr	ess (Street	and Number or R				in Code)	
<u>8</u>	d 2 si th an th an traur		Zelma Rice /Wife	(19pe. 1 mily			3	,	derland, MD		out, only of	, , , , , , , , ,	,p 0000)	
a)	f Heal		20a. Method of Disposition		20b. Pla	ce of D	isposition (	Name of	1	Date	20c. Loc	cation - City or	Town, State	
Ē	Page ent o nt: If ry or		1 → Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				onds UN			1/21/07	С	hesapeake	Beach	MD
altillo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral Service Lic	ensee 0			22. Name	and Addre	ess of Facility	_		•		
۵_	88 2 2 8		Gladys a.	Sewell				1451 Da	Funeral Hom ares Beach f	Road Prince		rick, MD.20		
		ŀ	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each lin	the death. e.	Do not	enter the r	node of dyi	ng, such as cardia	ac or respiratory	arrest,		Approxin Interval I Onset ar	Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Hypi	ox i'	2_						:		
	Examiner			Due to or as a	conseque	nce of):								
	(6)	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	nce of):		1						
	executed n and ial-transit	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated events	Resp	ina	for	my 1	An	est					
Š,	e exe	ш	resulting in death) Last	Due to (or as a	conseque	nce of):	. 0							
00/00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical		d										
o X O	ding F se as	/Me	IF FEMALE:	23c. If yes, outcome p	of pregnan	cv					2	3d. Date of deli	Ven/	
	death e atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal c	leath	3 ☐ Ectopi 5 ☐ Other		<sup>т</sup> у			Month	Day	Year
į.	t the c ay the	hysi	9 Unknown	9□Unknown										
Ų.	The law requires that the tate has been signed by the page 2 should be detached.	by P	Part II. Other significant conditions	contributing to death bu	it not result	ing in th	e underlyir	ig cause giv	ven in Part I.	1		se contribute to		
ecorus,	en sig	ed	Coronary	antery	dis	sea	se			1	Yes 2	□No 3□Pr	obably 4	Unknown
i i	law ru as be 2 sho	Completed	peripheral	vascul	2	de.	5Ra	12			opsy	24b. Were au	topsy findin	gs available if cause of
ב	The cate h	Con	diabetes	melli	hus					per 1□ Yes	formed?	death? 1 ☐ Yes	2 No	
N I G	Attending Physician: r death. ector: After this certifics by the funeral director,	Be	25. Was case referred to medical examiner?	Hospital:	_			Ott	hor:	eath (Check only				
5	Phys r this ral dir	<u>د</u>	1 → Yes 2 No  27. Manner of Death	28a. Date of Injur	v 2	R/Outpa 28b. Tim	atient 3 ne of	28c. Inju	4 Li Nursing	Home 5 ☐ Res			cify)	
200	nding th. : Afte fune	tion	1 Natural 5 ☐ Pending investigati	(Month, Day	Year)	Inju	iry M		rk? ]Yes 2 □ No					
2	Atter r deal ector by the	ifica	3 Suicide 6 Could not 4 Homicide determine		ry - At hom	ne, farm	, street, fac	tory, office			(Street and	d Number or Ru	ral Route N	umber,
5	rs afte ai Dir ed in	Certification:		Ballating, etc	(Opcony)					5.ty 01 11	, orare)	,		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s		(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of	examination	ledge, o on and/o	leath occur or investiga	red at the t tion, in my	ime, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the caus	e(s)
	the the multiple t	Medical	one)  29b. Signature and title of certifier	and manner sta	ted.			29c_Licens	se number		29d. Date	e signed (Monti	n, Day, Yea	-)
	FSFS			// //			1	()	A	_		- '	-	

Dew 5

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELMUT PFALT (00 HOD) Hal Rd

31. Date filed (Month, Day, Year)

32. Registre Signature

11-15-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Nancy Tetelpa Ramirez NOV 12 1010 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HICOMICO 50/136419 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Min 11-12-2007 1 □ M 2 1 F Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Berlin Maryland Worcester e filed within 72 hours after death with the I al Hygiene. other than "natural", or Items 23a or 28a-10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21811 115 Flower St. Apt. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Saltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Specify: Completed by Mexican hispanic 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) n/a College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Nancy Ramirez Moises Tetelpa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 115 Flower St., Apt. 6, Berlin, MD 21811 Nancy Ramirez/mother item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/19/07 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Licensee 2Holloway Tufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EXTREME PREMATURILE
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) P.0. 1 Yes 2 No 9☐Unknown 9 ☐ Unknown signed by the sign of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy performed? Yes 2 No this certificate 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 Yes 2 No death. filled in by the f 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36589 Nov. 12, 2007 ser in am

State Registrar

DHMH 17 Rev 1/2001

CARROLL

Redistrar's Signature

SAlisbury Md. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

			1 - State Certificate of Death Reg. No.										
			Decedent's Name (First, Middle, Last)							Date of Death     Month Day Year			
	Physici		JOHN	EDWARD		RANI	ΔΤ.Τ.		NOVEM		2007	9:05 P M	
	/Medio Examir		4a. Facility Name (If not institution, give		per)	IVANI		or Location of Dea			nty of Death	7.03 1	
	Exami	iei	ATLANTIC GENERAL				BERI	TNI		7.7	ORCEST	סקי	
	Funeval	-			Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of E	irth		place (State or Foreign ntry)	
	Funeral Director			1 <u>X</u> ) M 2□F	74	Yrs.	Months Days	Hours Min	JUNE 7	1933 1933		RYLAND	
			Usual Residence of Decedent				l		DOME /	, 1755	TIME	CILAND	
	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Examiner must be notified.		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
		Director	MARYLAND WORCESTER OCEAN CITY								1 □XYes 2 □ No		
			10e. Street and Number			JEAN C	10f. Zip Code	Zip Code		10g. Citizen	10g. Citizen of What Country?		
			161 SANDY HILL DRIVE				2184	0			,		
		Funeral	11. Marital Status 12. Was Decedent E			5 13		∠ Hispanic Origin? (S	Specify Yes or N		USA  14. Race - American Indian, Black, White, etc.		
		5	Armed Forces?  1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No				If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	В			
36		by	3 ☐ Widowed 4 ☐ With Divorced If Yes, Give Year or Dates: 19			5.5	1□Yes 2⊠XNo	Specify:	Spe	Specify: WHITE			
ŏ	72 hours 'natural', dical Exe		15. Decedent's E	1	1755		dent's Usual Occu	pation		16b. Kind of	Business/In	dustry	
15	s 1 end 2 should be filed within 72 h I Heelth and Mental Hygiene Item 27 Is marked other than "natu other traumatic event, the Madical	Completed	(Specify only highest gri	ade completed)		(Give	kind of work done DO NOT use retire	during most of wo	rking				
12			Elementary/Secondary (0-12) College (1-4or 5+)  8 SUPERVISOR MASS TRA						TRANS	TT			
9	filed Hygie other	ŭ	17. Father's Name (First, Middle, Last	)				18. Mother's Na	me (First, Midd				
a	2 should be filed and Mental Hygir Is marked other aumatic event, II	Be	JOHN E.	RAN	DALL			MARGA	RET :	5. C1	USHION	Ī	
2	should be nd Mental marked amatic ev	ျှ	19a. Informant's Name/Relationship (			10h Maili	na Address /Stree	t and Number or R					
Z a	12 s th an 7 is 1												
<u> </u>	1 en Jeel Jeel The the		KAREN M. UHLIK/DA	UGILER	20b. Pl			AVE., BA	Date Date	T			
ō	permit. Pages 1 end 2 Department of Heelth a Important: If item 27 is any injury or other tra		1 Burial 2 Cemetion 3 Removal from State										
<u> </u>			4 □Donation 5 □ Other (Special		CRE		OF DELM		/26/07	DELMAI	R, DEL	AWARE	
Baltimore, Maryland 21215-0036			21. Signature of Fugeral Service Lice	nsee)	1		2. Name and Addre						
ш	⊈ □ □ ■ d		HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975										
												Interval Between	
	Physician		Immediate Cause (Final disease or condition Production Production Production Production									Dinset and Death	
	/Medical		resulting in death)	a. Due to (or	as a consequ	ence of):		<u> </u>				3	
	Examiner		Morain Obstractive Pulmon Viscoge (cerc										
10		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ								
210	certificate be executed iding physicien and ise as the burial-transit	Examiner	Cause (Disease or injury that initiated events	C									
60	execun an an ial-tr	Exa	resulting in death) Last	Due to (or	as a consequ	ence of):				-			
121/6	sicie sicie	cai		d									
7/	ificat g phy as th	/Medicai											
×			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. I	Date of deliv	ery	
o. D. B.	The law requires that the death ste hes been signed by the etter bage 2 should be deteched for u	Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnan	h 2∏Fetal nt at time of de		Ectopic pregnanc Other (specify) _	у			Month	Day Year	
0.	the cy the	ys	9 Unknown	9□ Unknow	m								
~ 0	that	Y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to t								he cause of death?		
7	w requires that been signed to should be det	d by	Myelodysplasia 10 Yes 2 DNO							3 Probably Unknown			
12 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	v req beer shou	ete	Costo	Ad-	Dre	1.00			24a. Wa	c 20 24	h Moro outr	nosy findings available	
8nclal/ $3c - 2 - 3$ Records,	hes hes	Completed	Woney Artey Wisase						aut	opsy formed?	prior to completion of cause of		
3 00 1			<u>'</u>						1 ☐ Yes	25 No	1 ☐ Yes	2 No	
3 / K	Attending Physician: r death. ector: After this certifica by the funeral director, I	Be	25. Was case referred to medical examiner?	Hospitali C				26. Place of De	ath (Check only	one)			
080	Physical this call direction	မ	1 Ses 2 No Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)										
	ding F n. After funera	on:	27. Manner of Death  1 K Natural 5 Pending  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred Work?										
Sio	death death ctor: / the fi	cati	2 Accident investigatio				M 1	Yes 2 No					
$\mathcal{J}_{o}h_{N}$ Division	or Attenester deat Director:	ledical Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)									al Route Number,	
۵	ital c irs ef rai D ted ir												
	hound the hound		29a. Certifier (Check only (Ch										
	the H in 24 the F iplete	ed	one)	and manne	r stated.					, date and pige			
	To the Hospital or Att within 24 hours efter de To the Funeral Direct completely filled in by t	Σ	29b. Signature and title of certifier	/			29c. Licens		~	29d. Date sig	/		
			NV Woll		. ~		Do	7876	7	10	120	107	
-	1000		30. Name and address of person who	completed cause	of death (Item	23а) (Туре,	Print)	11	<del></del>	,	1 11	) - (	
	( - 0		Widden Foros	lecteage	\$ 12	07 6	postal	tegenes	tav	Mils	leel !	207 De 19944	
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	strar's Signat	ure	1	/					
	Registr	ar	NOV 26	ZUU/  🎉	MEIARI	10. 1	DONEL						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Henrietta Lola Faucette November 20, 2007 11:45 A <sup>™</sup> /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 44 Kings Wharf Place Charles Waldorf 8. Date of Birth (Month, Day, Yea Jan. 5, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2**K** F Months Days Hours 577-44-8988 71 Director 1936 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No Maryland Charles Waldorf Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Itams 23a 44 Kings Wharf Place 20602 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. hours after ☐ Yes 2 XNo Yes, Give 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Cafeteria Cook Board of Education othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other traumests. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Steven Rickman Myrtle Elizabeth Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James N. Faucette - Husband 44 Kings Wharf Place, Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens $_{11-24-07}$  Waldorf, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M01246 3035 Old Washington Road Jack Waldorf, MD 20601 **Huntt Funeral Home** 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANC /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Ussass or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No P.O. the detached 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 ☐ Yes 2 X No 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ion: 1 🗷 Natural 5 Pending investigation death. 2 🗌 No 2 Accident Diractor: in by the f Certificat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funaral C 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State NOV 2 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Yancey Alvin Rowe, Jr. November 14, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 2 Hours 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year **Funeral** Days 1 1 M 2 □ F 82 Director 579-30-4829 Aug. 14, 1925 Emporia, VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☑ Yes 2 ☐ No Director DC N/A Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code nit. Pages 1 and 2 should be filed within 72 hours after death with artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be 1 7721 16th St., N.W. 20012 Funeral U.S. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1⊠Yes 2□No 1943− If Yes, Give Year or Dates: 1946 Black, White, etc. 1 Never Married 2 Married African Maryland 21215-0036 1 ☐ Yes 2 🖾 No Completed by 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrator U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Yancey Alvin Rowe, Sr. Kathleen Ruffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Elizabeth Rowe / Wife 7721 16th St., N.W. Washington, D.C. 20012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'1. Cem. Nov. 27, 2007 Triangle,

22 Name and Address of Facility McGuire Funeral Service, Inc.

2300 Department or Important: If any Injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee Indre Thomps 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Rectal Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed buriai-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 1∐ Yes 2K No or Attending Physician: the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2x No 1 😿 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined

completely 5+1

Hospital

State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

CANDACE

31. Date filed (Month, Bay, Year) 3 32. Raistrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

112

4.

WILSON, MD - 1500 FOREST GLEN RD SILVER SPRING MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0061937

29d. Date signed (Month, Day, Year)